Authorization for Disclosure of Protected Health Information

Hamilton Psychiatric Services PA
Nighat Mirza, M.D.

1 Nami Lane, Suite 9
Hamilton, NJ 08619
Phone: 609-631-7770
Fax : 609-631-7774

I (Patients's Name / Guardian if minor):_____

hereby authorize Doctor / Facility Name (Information Realesed From) _____

to disclose information from the record of:_____ _____
Patient Name Patient Date of Birth

Purpose for Request

- ☐ **Release Proctected Health Information to Hamilton Psychiatric Services**
- ☐ **Transferring to Another Practice**
- ☐ **For personal use only (not transferring from practice)**
- ☐ **Relocation out of area:** _____
- ☐ **Insurance Change Related. PLEASE INDICADE CARRIER:** _____
- ☐ **Discuss with:** ☐ **Employer** ☐ **Family Member** ☐ **Friend** ☐ **Others:**_____
- ☐ **Others:** _____

Fill Name of Person / Facility Information Transfered to (required)

Name:_____ **Practice Name (if applicable)** _____

Address:_____

Phone Number:_____ **Fax Number:**_____

The following information is to be released: (Please check one)

☐ Entire Medical Record. Records specifically protected under State and Federal Confidentiality Statues. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and Federal law and prohibits any further disclosure without written consent of the persons to whom it pertains or otherwise provided by law.

☐ Only specific portions of the medical record. Itemize portions of record and time period of records to be released.

☐ **Inital Evaluation/Exam** ☐ **Current Medication** ☐ **Progress Notes** ☐ **Blood Work** ☐ **Radiology Repots**

☐ **ECG Reports** ☐ **EKG Reports** ☐ **Psychological Tests** ☐ **Discharge Summary** ☐ _____

Date of Service / Comments: _____

indicate specific records that may not be released: _____

I understand that this authorization will remain in effect for 180 days or until I provide a written notice of revocation to Hamilton Psychiatric Services Privacy Office at the address listed above.The revocation will be effective immediately upon Hamilton PsychiatricServices receipt of the written notice.I understand that revocation may not be made if the action has already been acted upon based on prior authorization.

_____ _____
Patient Signature **Date of Signature**

_____ _____
Witness **Signature of Reponsible Party**

If patient is not able to sign, complete the following

☐ **Patient is a minor _____ Years of age.**

☐ **Patient is unable to sign Because:** _____