General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone: _____
SSN: _____Date of Birth: _____/_____/_____

I authorize_____to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Doctor notes
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically)

Please send the records listed above to (doctor requesting records):

___ James Orsini, MD
___ John Conti, MD
___ Said Saleh, MD
___ James Orsini, Jr., MD
____ Alan Lippman, MD
____ Hemalatha Vasireddy, MD
____ Sita M. Yerramalli, MD

Please choose office location:

____ 36 Newark Avenue, Suite 304, Belleville, NJ 07109 – Ph: 973-751-8880; Fax: 973-751-8950

____ 1 Bay Avenue, Suite 2, Montclair, NJ 07042 – Ph: 973-744-8000; Fax: 973-744-8340

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*