

TOTAL PATIENT CARE, LLC

Authorization to Release Medical Records

Name of Patient: _____ **Date of Birth:** _____

I, the undersigned, hereby authorize Total Patient Care, LLC (the "Practice") to use and/or disclose, or to provide me access to, the protected health information (PHI) described below from the medical record(s) of the above-named patient for the purpose specified in this authorization.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care / Clinical Quality

Protected Health Information (PHI) to Be Disclosed or Accessed

Colonoscopy Report: _____ Facility: _____

Mammography Report: _____ Facility: _____

Diabetic Eye Exam: _____ Facility: _____

Other: _____ Facility: _____

The above information may be released to:

TOTAL PATIENT CARE LLC
459 Jack Martin Blvd
Brick, NJ 08724
Phone: 732-785-9201
Fax: 732-458-3148

I understand that my medical records and protected health information (PHI) are confidential and will not be used or disclosed without my written authorization, except as otherwise permitted or required by law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy laws. I further understand that this authorization is limited to the specific information described above and does not authorize the release of any other records.

I understand that I may revoke this authorization in writing at any time.

Date: _____

Patient Signature: _____