Attention-MD New Jersey

Andrew S. Burstiner, MD FAAP
766 Shrewsbury Avenue #400
Tinton Falls, NJ 07724

Medical Records Release Authorization Form

Patient Information:
Patient's Name: ______________________________________ Date of Birth: ____________________________
Address: ____
City/State/ZIP: ____
Phone Number: ____
Email Address: ____

Authorization for Release of Medical Records:
I, ___________________________________, hereby authorize the release of my (my child's) medical records from Attention-MD New Jersey to the following individual or entity:
Name of Recipient: ____
Address: ____
City/State/ZIP: ____
Phone Number: ____
Fax Number: ____

Purpose of Disclosure:
This disclosure of medical records is being made for the following purpose (e.g., second opinion, continuity of care, legal, insurance claim, personal records):
Purpose: _____________________________________

Records to Be Released:
I authorize the release of the following medical records:

- ☐ Entire Medical Record
- ☐ Specific Date Range: From ____________ to ___________

Fee Structure for Copies of Records:
I understand that the last office visit notes are provided free of charge. For any additional copies of medical records, an administrative fee of $10 will be charged, along with the following per-page charges:

- $1 per page for pages 1-25
- $0.50 per page for pages 26 and over

Release and Signature:
I understand that my medical records may contain sensitive and confidential information about my health and medical history. By signing this form, I consent to the release of my medical records as specified above and agree to the associated fees for copies.
Patient/Parent/Guardian Signature:____ Date:___________________

Expiration of Authorization:
This authorization for the release of medical records shall remain in effect until ________________after which it will automatically expire.

Revocation of Authorization:
I understand that I may revoke this authorization at any time by providing written notice to [Doctor's Name/Practice Name], except to the extent that action has already been taken in reliance on this authorization. I understand that revocation may not apply to information already disclosed to the recipient.
Patient's Signature for Revocation (if desired): _______________________________________ Date: ____________________