PATIENT AUTHORIZATION FORM
RELEASE OF MEDICAL INFORMATION
ALLERGY GROUP NJ

I hereby authorize **Allergy Group NJ** to disclose necessary health information to:

____ for

____

Patient's Name

This authorization shall remain in effect from the date signed below until authorization is revoked in writing.

I understand that:

- I may inspect or copy the protected health information to be disclosed.
- I may revoke this authorization in writing by contacting your office at the above address, attention Privacy Officer.
- Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA.

Patient Name: ____

Signature of Patient or Guardian: ____

Relationship to Patient (if signed by a personal representative of patient)_______________

Date: ___________________

This may be faxed back to **Allergy Group NJ**, 732-349-0117 for Toms River, 732-683-1070 for Manalapan and 732-739-1406 for Holmdel. Information will not be released without a signed authorization.