Authorization for Release of Protected Health Information
PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Name:_____ Street Address: _____ City, State Zip: _____ Email Address: _____	Date of Birth: _____ Social Security#: _____ Best Contact# (_____)_____
RELEASE INFORMATION FROM: ☐ **To:** ☐ Name of Facility or Practice _____ Mailing Address: _____ Phone Number: _____ Fax Number :	**RELEASE INFORMATION FROM:** ☐ **To:** ☐ **Lifeline Primary Care LLC** **780 Route 37 West, Suite 220** **Toms River, NJ 08755** **Ph: 732.279.3681** **Fax: 732.279.6043**

PURPOSE OF RELEASE: ☐ Personal ☐ Medical/Continuity of Care ☐ Insurance ☐ Legal Transfer:

DATES OF TREATMENT TO BE RELEASED: From_____To: _____ ☐ All available

INFORMATION TO BE RELEASED (check all that apply): ☐ Demographics ☐ EKG (image) ☐ Cardiac Testing Reports (Echo, Stress test, Cath etc) ☐ Pathology Reports ☐ Office Notes/MD Dictation	☐ Physical / Occupational Therapy Records ☐ Billing Statements ☐ Laboratory Reports ☐ Radiology Reports ☐ Pulmonary Function Test Reports ☐ Other:_____

FEES MAY APPLY. Request for more than ten pages will be processed by our copying service who will contact you about charges that may apply pursuant to SC Code Section 44-115-80.

METHOD OF DELIVERY: ☐ **Fax** ☐ **US Mail** ☐ **Electronic (email)_____**

I UNDERSTAND THAT:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- We will not share or use my health information without permission other than as permitted or required by the law. I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature or earlier dated listed here : _____

Patient's Name:_____ Patient Signature:_____

Date:____/_____/_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof maybe requested):

☐Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse

☐ Parent ☐ Adult Child ☐ Affidavit/Next of Kin ☐ Other:_____