OSCAR PEDIATRICS
318 Chestnut St, Roselle Park, NJ 07204
Tel: (908) 653-1001 Fax: (908) 653-1037

AUTHORIZATION TO RELEASE OR USE HEALTH INFORMATION

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(Patient-Last Name, First Name) *(Date of Birth)* *(Parent/Guardian Cell #)*

1) I authorize *(Mandatory field)*: ………………………………………………………………………………
(Name of Doctor or individual or entity in possession of the Health information)

Address: *(Mandatory field)*: ………………………………………………………………………………

Fax *(Mandatory field):* ……………………………… Ph *(Mandatory field):* ………………………………

to disclose a copy of my medical records to ______OSCAR PEDIATRICS____________
(Person to whom disclosure is being made)

2) The information to be disclosed is as follows:

☐ All Health records including, but not limited to AIDS/HIV and other information such as alcohol / chemical dependency and psychiatric diagnosis and treatment records

☐ Immunizations ☐ Labs ☐ Specialist Visits ☐ Radiology Results ☐ ER / Inpatient Discharge Summary

3) The information for which I am authorizing will be used for the following purpose:

☐ Moving ☐ Switching PCP

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation; this authorization shall remain in full force and effect and shall not otherwise expire.

……………………………………………… ………………………………………………
(Patient, Parent, or Legal Guardian's Signature) (Relationship to patient)

……………………………………………… ………………………………………………
(Name of Patient, Parent, or Legal Guardian) (Date)