MONMOUTH-OCEAN NEUROLOGY

PETER P. BARCAS, M.D.
ALAN D. DEUTSCH, D.O.
STEPHEN J. MARTINO, M.D.
PAUL M. KOSTOULAKOS, D.O.
MARY SEDAROUS, M.D.
HUMA BAQUI, M.D.
BRIAN M. FLYNN, D.O.

BOARD CERTIFIED IN NEUROLOGY

JERSEY SHORE MEDICAL ARTS BUILDING
1944 CORLIES AVE, SUITE 206
NEPTUNE, NJ 07753
P - (732) 774-8282
F - (732) 774-4407

OCEAN MEDICAL PARK
190 JACK MARTING BLVD, BLDG B3
BRICK, NJ 08724
P - (732) 785-1500
F - (732) 785-0116

MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION
(PLEASE PRINT)

Patient Name: _____ Patient Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SS#: _____

REQUESTOR / RECIPIENT INFORMATION

I hereby authorize (complete name and address of facility you wish to have records released from):

Monmouth Ocean Neurology
1944 Corlies Ave, Suite 206
Neptune, NJ 07753

Please disclose the following health information to: (**MUST** have complete name, address, phone and fax) – Incomplete forms will **NOT** be processed.

_____

_____

_____

___ DISCHARGE SUMMARY ___ PATHOLOGY REPORTS ___ EMERGENCY REPORTS ___ HISTORY & PHYSICAL ___LABORATROY REPORTS

___ PROGRESS NOTES ___RADIOLOGY REPORTS ___ OPERATIVE REPORTS ___ ECG / EEG / CARDIAC CATH

___OTHER _____

_____ _____ Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

I DO I DO NOT

PURPOSE OF DISCLOSURE:
___ REFERRAL TO SPECIALIST ___ INSURANCE ___ WORKERS COMP ___ LEGAL INVESTIGATION ___ DISABILITY ___ PERSONAL

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization. _____

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date: _____

I understand that any disclosure or information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization. _____

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Description of Representatives Authority (Witness Signature Required) Signature of Witness

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NOTE ALL MEDICAL RECORDS ARE SENT DIGITALLY AND THERE ARE PROCESSING FEES FRO PATIENTS REQUESTING RECORDS TO BE SENT TO THEMSELVES OR ANY BUSINESS OTHER THAN A PHYSICIAN'S OFFICE