West Orange Family Medical Care, PA

Diplomate, American Board of Family Medicine
Michael G. Mercado, M.D., FAAFP, CMD

_____ Print Patient full name

_____/_____/_____ Birth date

_____ Street address

_____-_____-_____ Social Security Number

_____ City/State/Zip

(_____)_____-_____ Home phone number

I, _____, do hereby authorize WEST ORANGE FAMILY MEDICAL CARE, P.A. to receive:
patient name

_____ Discharge Summary
_____ History & Physical
_____ Progress Notes
_____ Operative Notes
_____ Pathology Reports
_____ Laboratory Reports
_____ Radiology Reports
_____ ECG/EEG/Cardiac Cath
_____ Emergency Reports
_____ Entire Chart
_____ Other _____

ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO COMPLY WITH YOUR REQUEST. (please check one)

_____I do _____I do NOT 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.

RECEIVE INFORMATION FROM: _____
Name of Company/Agency/facility/Person

Phone #: _____ _____
Street Address

Fax #: _____

_____
City/State/Zip

PURPOSE OF DISCLOSURE:

____ Referral to specialist ____ Insurance ____ Workers Comp ____ Change of Doctor/Provider
____ Legal Investigation ____ Disability determination ____ Self ____ Continuing care
Other (please specify) _____

Please provide the best telephone number in the event we need to contact you (home, work or cell)
(_____) _____-_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished many not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate

Date

1092 S. Dillard Cir[illegible] Fax 407.877.8495