AUTHORIZATION REQUEST FOR RECORDS

NJ MEMORY CENTER

80 Pompton Ave., Suite 106
Verona, NJ 07044
Phone: 201-577-8286
Fax: 201-479-0299

I, _____ / _____ authorize the NJ Memory Center to receive
(patient name) (date of birth)

my medical records from the following provider and/or treating providers within organization:

Name: _____

Agency/Office: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be disclosed:

Entire record: _____ Doctor/Provider Notes: _____

Medical, Lab, or Imaging Record Reports (specify): _____

Prior neuropsychology consult, assessment, & report(s): _____

Applicable for Authorization Via:

Phone/Oral Communication: _____ Fax: _____ Mail:_____

This Authorization shall cover actions by and for NJ Memory Center and all of their respective employees. I authorize the use and disclosure of my individually identifiable health information to NJ Memory Center for diagnostic purposes.

I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and my portion of payment for my health care will not be affected if I do not sign this form. I understand that I may refuse authorization to disclose all or some of the healthcare information, but that refusal could result in improper diagnosis or treatment, denial of coverage or a claim for health benefits by my insurance company. I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization is voluntary.

This authorization shall remain in effect for one year, or until_____ (expiration date).

_____ _____ _____
Signature Print Name Date

_____ _____ _____
NJMC Representative Print Name Date