Bergen Medical Alliance PA
180 Engle Street, Englewood, NJ 07631
1 N. Washington Ave, Bergenfield NJ 07621

MDPartners
ENGLEWOOD HOSPITAL AND MEDICAL CENTER
Member of MD Partners of EHMC

**AUTHORIZATION TO OBTAIN MEDICAL RECORDS**

TO: _____

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE AND SEND COPIES OF MY MEDICAL RECORDS TO:

__ALICE ABRAHAM, MD
__DANA CORRIEL, MD
__KATALIN FRISCH, MD
__RADHIKA KAPOOR, DO
__MING-KONG LIU, MD
__CLIFFORD SIMON, MD
__GLENN BRAUNTUCH, MD
__MICHAEL DEGENNARO, MD
__SHERNETT GRIFFITHS, MD
__SRIKANT KONDAPANENI, MD
__ROBERT MALOVANY, MD
__JULIE YIP, DO
__ELAINE CONG, MD
__MITCHELL ENGLER, MD
__NANDITA JOSHI, MD
__ESTHER LEE, MD
__KILLOL PATEL, MD

THE COMPLETE MEDICAL RECORD IN YOUR POSSESSION, CONCERNING TREATMENT DURING THE PERIOD FROM _____ TO _____

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
_____Psychiatric Care ____Genetic Information _____Treatment for alcohol and/or drug abuse
_____Sexually Transmitted Disease(s) ____Tuberculosis

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested. I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expire on _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I will be given a copy of this form after I sign it.

PATIENT NAME: _____ BIRTH DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

_____ DATE: _____
SIGNATURE OF PATIENT

_____ _____
WITNESS NAME WITNESS SIGNATURE