AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
Release from:
Windsor Regional Medical Associates, LLC
300A Princeton-Hightstown Rd Ste 102
East Windsor, NJ 08520-1421
Phone: 609-490-0095 | Fax: 609-490-0091

PATIENT INFORMATION

Full Name: ___________________________________ DOB: ____/____/______

Address: ____

City/State/Zip: ___________________________________ Phone: ___________________

RELEASE TO (Facility/Provider):

Name: ____

Address: ____

Phone: ___________________________ Fax: _______________________________

RECORDS REQUESTED

Please release ALL medical records for the past TWO (2) YEARS unless otherwise specified here: _______________________________________. Include office notes, labs, imaging reports, consults, operative reports, pathology, and medications.

SENSITIVE INFORMATION

I authorize release of records including mental health, psychiatric treatment, HIV/AIDS, sexually transmitted infections, reproductive health care, genetic testing, and other infectious diseases.

SUBSTANCE USE DISORDER RECORDS (42 CFR Part 2): I specifically authorize the release of substance use disorder diagnosis and treatment records.

Patient Initials here for authorizing SUD Records: ____________

This authorization is made pursuant to HIPAA (45 CFR 160 & 164), 42 CFR Part 2, N.J.S.A. 26:2H-12.8 and applicable NJ regulations.

PURPOSE OF REQUEST IS: ____

This authorization expires one (1) year from signature unless otherwise specified: ___________________.
I understand I may revoke this authorization in writing at any time except to the extent action has already been taken. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing. Information disclosed may be subject to redisclosure as permitted by law.

AUTHORIZED SIGNATURE

Signature: ___________________________________ ________Date: ____/____/______

Printed Name: _______________________________________ Relationship (if not self): _____________________