RADIOLOGY ASSOCIATES OF RIDGEWOOD, P.A.
Waldwick, New Jersey

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS & INFORMATION

I, _____born on _____
((**Name of Patient)** **(Date of Birth)**

do hereby consent and authorize Radiology Associates of Ridgewood, P.A. to disclose to:

_____located at _____
(Name, Title or Organization) **(Address)_**

the following records:

_____
(Above information should include the date(s) of service, type of service provided, level of detail to be released (report/films, etc.)

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to Kathleen Vedilago, Privacy Officer at Radiology Associates of Ridgewood, P.A. 20 Franklin Turnpike, Waldwick, NJ 07463**.** I understand that a revocation is not effective to the extent that Radiology Associates of Ridgewood, P.A. has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that Radiology Associates of Ridgewood, P.A. will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences to me of refusing to sign this authorization.

I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient if the recipient is not required by law to protect the privacy of the information.

I understand that I will receive a copy of this authorization, if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ **Date** _____
Signature of Patient or Personal Representative

_____ _____
Name of Patient or Personal Representative **Description of Personal Representative's Authority**

_____
Witness to Signature(s)
This authorization will be in force and effect until _____(Date of Expiration).

NOTE to Recipient of Information: This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CFR § 2.1 et seq; N.J.S.A.. 26.5c-1et. Seq.) Federal or State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR § 2.1 et seq; N.J.S.A.. 26.5c-1et. Seq.). A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal or State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
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