Medical Associates of Westfield **Tel: 908-233-1444**
324 E. South Avenue Westfield, NJ 07090 **Fax: 908-654-0226**

AUTHORIZATION TO RELEASE HEALTHARE INFORMATION

Patient's Name: _____ D.O.B.: _____

Previous Name: _____ SS #: _____

I request and authorize _____ to release healthcare information of the patient named to:

_____ Peter J. Weigel, MD _____ Patricia Ruggeri- Weigel, MD

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates: _____

_____

☐ All Healthcare information

☐ Other:

☐ Yes ☐ No I authorize the release of my STD results, HIV/ AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient's signature: _____ Date signed: _____

PLEASE SEND ALL RECORDS WITHIN 10 DAYS. THANK YOU.