ASSOCIATES IN PRIMARY CARE, P.A.
Thomas Pitoscia, MD Silvio A. Quaglia, MD
Lauren Baron, RPA-C Jeanine Ferrao, APN-C
25 East Willow Street
Millburn, New Jersey 07041
Phone: (973)-379-5055 Fax: (973) 379-5324

Patient Name	Birth Date	Address

I hereby authorize and request Associates in Primary Care to disclose protected health information concerning the above named individual to:

_____
_____
_____

Name(s) and address(s) of person(s)/organization(s) to which disclosure is to be made.

For treatment date(s):_____
For the following purpose(s):_____

Delivery Method of Records: : □ Mail (Paper) □ Mail USB Flash Drive (Digital) □ Pick-up (Paper) □ Email/Electronic (Digital)
Check only ONE □ Fax

For Digital Requests:
E-mail:_____
Preferred Password:_____
Must contain 8-12 characters

CHECK TYPE OF INFORMATION AUTHORIZAED TO BE USED AND/OR DISCLOSED

□ Entire Record (will not include Billing records or records not prepared by or on behalf of Associates in Primary Care unless those items are also selected.
□ Physician Progress Notes
□ Lab Reports
□ Imaging/Radiology Reports
□ Cardiac/Imaging Reports (EKG/Holter/Echo…)
□ Other Diagnostic reports (PFT, audiometry…)
□ Billing Records
□ Records not prepared by or on behalf of Associates in Primary Care. Associates in Primary Care cannot be responsible for the completeness or accuracy of such records.

There is a flat fee of $6.50 for each record request. If you have extensive records you may be charged a higher fee that covers that actual cost to fulfill your request. If your request exceeds $6.50 you will be notified for approval prior to completing the request.

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is let blank, the authorization shall remain ineffective for 60 days after the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to the diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes, and information relating to HIV testing, HIV status or AIDS.
_____ Initial here if you do not wish this information to be disclosed

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of record, including a charge for labor and supplies, and the reasonable cost of all duplication of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization any time except to the extent that action has been taken in reliance upon it or except as otherwise stated in Associates in Primary Care's privacy practices by mailing or hand-delivering written notification to the following person: Privacy Officer, Associates in Primary Care, 25 East Willow Street, Millburn, NJ 07041.

_____ _____
Date *Signature of Individual/Individual Representative*

_____ _____
Printed name of Representative and Relationship *Representative address and telephone number*

_____ _____
Date *Signature of Witness*