# The Performance & Health Institute

## MEDICAL RECORDS RELEASE FORM

I, _____, authorize JWP Medical Services LLC to release a
(Person requesting medical records)
copy of my medical record to: _____

Please Provide Records Via

( ) *Regular Mail* _____

( ) *CD in PDF format* _____

( ) *FAX* _____

Reason for Request: ( ) moving ( ) changed insurance ( ) transferring care for other reason

( ) release info to specialist ( ) other

I specifically authorize the release of the following:

_____ Pertinent Record (includes the previous 3 years of office notes, lab work, and ALL other pertinent tests)

_____ Entire Chart (please be aware the charge for this may be several hundred dollars, depending on the size of the chart. The entire record will remain on file indefinitely in our electronic record if there is ever a need to access it, and most physicians will not require the entire chart)

Patient Comments/Note_____

_____

_____

I expressly and voluntarily authorize disclosure of the above medical record information. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release is effective for 90 days from the date signed, unless otherwise specified as follows:

_____

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained for me, or unless such disclosure is specifically required or permitted by law.

_____ _____

Patient's Name (if other than requestor) Patient's DOB

_____ _____

Signature Date

335 Chestnut Street
Norwood, NJ 07648
201.899.3560