Jeffrey Weiss, M.D., P.A.
44 Route 23 North, Suite 6
Riverdale, NJ 07457
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Authorization for Release of Medical Records

Patient Name _____ Date of birth_____

Address_____ Contact Number_____

_____

Authority to Release Protected Health Information

I hereby authorize ____Jeffrey Weiss, MD, PA____ to release the information identified in the authorization form from the medical records of _____ and provide such information to:

Name: _____

Address: _____

Phone: _____

Fax: _____

Information to be Released-covering the periods of health care

From _____ to (date) _____ ☐Entire Medical File

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be “at the request of the individual”):

Signature _____ Date: _____

Relation to the patient _____

***Note: Please allow 24-48 hours for your request to be completed.**