Alexander Road Associates
707 Alexander Rd.
Bldg. 2, Suite 202
Princeton, NJ 08540
Phone (609) 419-0400
Fax (609) 419-9200

RELEASE OF RECORDS FORM

I _____ hereby authorize Alexander Road Associates to disclose medical records to the following persons regarding patient:

Name: _____ Date of Birth: _____
Contact number: _____ Email: _____

Purpose of Disclosure: _____
_____
_____

Records are to be released to the following parties:

Person/Organization and Address: _____
_____
_____
Phone # (___) _____ Fax # (___) _____

Person/Organization and Address: _____
_____
_____
Phone # (___) _____ Fax # (___) _____

Person/Organization and Address: _____
_____
_____
Phone # (___) _____ Fax # (___) _____

Please be aware that there is a $1 per page charge for reproducing records. We waive this charge when sending records to doctors, medical professionals, hospitals and other medical facilities.

_____ _____
(Patient Signature) **(Signature of Responsible Party {when applicable})**

_____
(Date)

To the recipient:

This information has been disclosed to you from records whose confidentiality is protected by state & federal law. New Jersey and federal law prohibits you from making further disclosure of this information, unless further disclosure if expressly authorized by written consent of the persons to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and will expire one year from the date of signature.