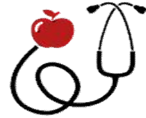

444 Market Street, Suite 2B
Saddle Brook, NJ 07663
Phone: 201-897-3099 Fax: 201-794-0335

Medical Information Release Form
(HIPAA Release Form)

To: Name:____
Address:____
Telephone No:________________________Fax:___________________________

I ______________________________Date of Birth: _______________ hereby request that you release to:

Balance Medical Care, 444 Market Street, Suite 2B, Saddle Brook, NJ 07663, Telephone: 201-897-3099, Fax: 201-794-0335, a report of my diagnosis, treatment, prognosis and recommendation, forward all clinical medical documentation, imaging, blood work, immunizations, procedural documentation, hospitalizations, medication's about me as may be necessary.

I understand that under the HIPPA act of 1996, I have certain rights regarding my protected health information. I understand that this information can and will be used to: direct my treatment and plan, obtain payment from third party payer, follow up with multiple healthcare providers whom are related to my treatment directly or indirectly, conduct normal healthcare operations such as quality assessment and physician certifications.

I understand that I may request in writing how my private health information is used, or how it is used to carry out treatment, payment or healthcare operations. I understand that you are not required to agree to my restriction requests but if you do agree, then you are bound to abide by such restrictions.

Signature:___________________________________Date:_______________________________________

Updated August 2018