



## **New Image Medical Center**

103 Parker Road  
West Long Branch, NJ 07764  
*tele: (732) 923-1777*  
*fax: (732) 923-1772*

### **Authorization for transfer of your medical records to New Image Medical Center**

#### **Form Instructions**

**You must complete pages 2-3 of this Patient Authorization Form if you are authorizing another medical practice or institution to release (disclose) any portion of your health care information to New Image Medical Center.**

***Its as Easy as One, Two, Three.....***

- 1.) **Fill out Section #1:** This section contains important Patient Information
- 2.) **Fill out Section #2:** This section tells your previous provider what health information you would like to **release** to New Image Medical Center and for what purpose.
- 3.) **Fill out Section #3:** This section tells your previous provider that you have read and understand the Terms of this Patient Authorization.



**Section #3: Terms of this Authorization**

**Please indicate that you have read and understand the terms of this**

**Authorization.** If you need assistance or have questions, please call (732) 923-1777.

- I understand that **[Provider]** will not condition my treatment performed by **[Provider]** and staff or condition the approval of referrals to specialists or hospitals on my signing this Authorization.
- I understand that **[Provider]** will release my health information as directed by the terms and conditions of this Authorization. I understand that information once released according to this Authorization is out of **[Provider's]** direct control and can no longer be safeguarded by **[Provider]** or prevent such information from re-disclosure by the recipient.
- I understand that I may revoke this Authorization in writing at any time.
- I understand that this Authorization will remain valid for 90 days from the signature or until (enter date or event here) \_\_\_\_\_, or until I revoke it in writing.
- I have read and understand the terms of this Authorization and I hereby authorize the release of my health information in the manner described above.

\_\_\_\_\_  
Signature of Individual/Designated Personal Representative\*\* Date

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Printed name of Personal Representative

*\*\*Note: If this form is signed by anyone other than the patient, the Patient Authorization is not valid unless your Designated Personal Representative documentation is on file with [Provider].*

**If Individual is a minor**, please complete the information below:

\_\_\_\_\_  
Signature of Parent or authorized  
Legal Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Parent or Legal Guardian