J. Calvin Chatlos, MD
973 Holmdel Road
Holmdel, NJ 07733
Phone: 732-834-0368 FAX: 732-834-9891

AUTHORIZATION TO RELEASE / RECEIVE HEALTH INFORMATION

PATIENT NAME: _____ D.O.B.:_____ PHONE: _____

ADDRESS: _____

I hereby authorize: Name _____

Address _____

_____

_____

to release / receive my health information to / from **J. CALVIN CHATLOS, MD.**

The information to be released / received and used by the above is for the following purpose:
_____

This authorization is limited to the following dates of treatment: FROM_____ TO _____

Information to be released / received:

- EMERGENCY ROOM RECORD
- EVALUATION AND RECOMMENDATIONS
- PROGRESS NOTES
- OTHER_____
- CONSULTATIONS
- LAB, X-RAYS & TESTS
- DISCHARGE SUMMARY
- COMPLETE RECORD

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

This release demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individuality Identifiable Health Information (Privacy Standards), 45 CFR 160 & 164 and Federal Regulations 42 CFR Part 2 and all federal regulations and interpretive guidelines promulgated thereunder. **The recipient of this information may not disclose this information unless another authorization is obtained from me or unless such disclosure is required or permitted by law (42 CFR Part 2).** The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to DR. CALVIN CHATLOS. I understand that this revocation will not apply to the extent that action has already been taken to this authorization. This authorization will automatically expire in one year from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules

PATIENT SIGNATURE: _____ DATE: _____
PARENT OR
GUARDIAN OF MINOR:_____RELATIONSHIP:_____DATE:_____.

WITNESS: _____ DATE:_____

④ COPY OF AUTHORIZATION TO PATIENT
(Revised 2/8/2023)