ATLANTIC SHORE MEDICAL, PA.
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ **_____/_____/_____**
Name **Birth Date**

_____ **_____-_____-_____**
Street Address **Social Security Number**

_____ **(_____)_____-_____**
City/State/Zip Code **Phone Number**

ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO COMPLY WITH YOU REQUEST

_____ Discarge Summary	**_____Pathology Reports**	**_____Emergency Reports**
_____ History & Physical	**_____Laboratory Reports**	**_____Entire Chart**
_____ Progress Notes	**_____Radiology Reports**	**_____Other _____**
_____ Operative Notes	**_____ECG/EEG/Cardiac**	**_____**

I _____, do hereby authorize ATLANTIC SHORE MEDICAL, PA. to release:

:_____
Doctor/Facility Name

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

PLEASE RELEASE INFORMATION TO:

Atlantic Shore Medical, PA
Lookman K. Odejobi MD
2100 Corlies Ave Suite 7
Neptune, NJ 07753
Tel: (732)776-9776 Fax: (732)776-9882

PURPOSE OF DISCLOSURE:

___ Referral to Specialist	**___ Insurance**	**___ Workers Comp**	**____ Change of Doctor/ Provider**
___ Legal Investigation	**___ Disability Determination**	**___ Self**	**____Continuing Care**

___ Other _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations.

_____ **_____**
Signature of Individual or Guardian **Date**