# OCEAN HEALTH & WELLNESS CENTER

## Medical Records Release (Authorization) Form

### PATIENT IDENTIFICATION

Patient Full Name: ____________________

Date of Birth: ____________________ Email Address: ____________________

Social Security Number: ____________________ Phone Number: ____________________

Address: ____________________

### AUTHORIZATION FOR USE/DISCLOSURE TO: ______________________________

By signing this document, I, the above-named, hereby grant permission for the use or disclosure of my health information as outlined below. I understand that this information may include records maintained by the healthcare provider concerning my physical or mental health or condition, treatment received, and billing records related to my healthcare.

Patient Signature: ________________________________ Date: ____________________

### TYPE OF AUTHORIZATION

Please select one:

☐ **Comprehensive Disclosure**: I authorize the disclosure of all my health-related information.

☐ Office Visit Notes ☐ Labs Reports & Diagnostic Studies ☐ Consultation Reports

### AUTHORIZED RECIPIENT INFORMATION

I designate the following individual or entity to receive the health information specified:

Name of Authorized Party: ____________________

Organization: Shore Health & Wellness Center

Phone Number: (732) 244-8666 Email Address: Shorehealth1@Outlook.com

Address: 137 Atlantic City Blvd., Beachwood, NJ 08722