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Patient Information Release Form

In accordance with the new Federal and HIPPA (Health Insurance Portability and Accountability Act) regulations, any medical information pertaining to you will only be disclosed to the person(s) indicated below. If they are NOT listed below, no information will be disclosed at any time. Thank you for your cooperation.

Date: _____

NAME

RELATIONSHIP

_____ I do not wish to have any of my health-related information released to anyone other than myself.

Patient's Signature _____

Any changes of patient release information must be in writing ONLY.

1820 State Route 33, Suite 4B, Neptune, NJ 07753, (732) 776-8500, Fax (732) 776-8946
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