Grossman Chiropractic & Physical Therapy

South Brunswick
397 Ridge Rd. STE 2
Dayton, NJ 08810
p: (732) 438-8700
f: (732) 438-8705

Highland Park
1001 Raritan Ave.
Highland Park, NJ 08904
p: (732) 572-2225
f: (732) 985-4875

Date _____ **Patient Name** _____ **DOB** _____

Address _____ **SSN:** _____

I authorize Grossman Chiropractic & Physical Therapy, LLC to release copies of my medical information for the period of:

_____ **to** _____ as stated below.

To _____

_____

Street _____

City, State, Zip: _____

Phone / Fax _____

From:
Grossman Chiropractic & Physical Therapy, LLC
1001 Raritan Avenue
Highland Park, N.J. 08904
T: (732) 572-2225

- ☐ ORTHOPEDIC REPORT / EVAL
- ☐ HIV / A.I.D.S
- ☐ ALL DIAGNOSES
- ☐ PROGRESS NOTES
- ☐ DISCHARGE SUMMARY
- ☐ RELEASE TO RETURN TO WORK
- ☐ HISTORY & PHYSICAL EXAM
- ☐ ANY RESTRICTIONS FOR WORK
- ☐ ENTIRE MEDICAL FILE

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVORIAL OR MENTALHEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASE, A.I.D.S AND HIV information, as applicable.

- The purpose for the release of this information is for medical records
- I do not wish the following information released.

_____

This authorization will remain in effect for three years from the signature date unless limited here, in which case it will expire on:

_____

If I wish to revoke this authorization before the termination date listed above, I must provide written notice to Grossman Chiropractic & Physical Therapy, LLC. Revocations will not have any effect on any action Grossman Chiropractic & Physical Therapy, LLC has already taken in reliance on the Authorization prior to it receiving my written revocation.

I may refuse to sign or may revoke at any time, this authorization for any reason and that refusal or revocation will not affect the commencement, continuation or quality of my treatment at Grossman Chiropractic & Physical Therapy, LLC unless it is necessary to make an eligibility determination, develop a plan or service, or to provide services.

I have read this authorization and have had the chance to ask questions about the use and disclosure of my health information. By signing below, I voluntarily authorize Grossman Chiropractic & Physical Therapy, LLC to use my health information in the manner described above.

Patient or Guardian Signature:_____ **Date:**_____

If this form is signed by a parent or guardian, please complete the following:

Print Name of Parent or Guardian:_____ **Relationship**_____