Authorization to Release Records and Information

I, _____, born on _____
(Name of Patient) **(Date of Birth)**

Do herby consent and authorize _____
(Doctor of whom we are requesting records)

Located at _____
(Address)

to release my complete medical records to:

Advanced Medical and Cosmetic Center, LLC
208 Harristown Road
Glen Rock, NJ 07452
Phone: 201-882-1050 Fax: 201-882-1040

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing.

_____AFFIRMATION OF RELEASE_____

I give _____permission to release
(Doctor of whom we are requesting records)

All information from my complete medical records to:
Advanced Medical and Cosmetic Center, LLC

I terminate any agreements I have made with my providers to restrict my medical records and any associated HIPPA protected health information and I instruct my providers to release and disclose my entire medical record without restriction.

_____ _____
(Signature of Patient/Representative and Relationship) **(Date signed)**