



Center of Excellence in Pain Management, Physical Medicine & Rehabilitation

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CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Date: ___/___/___

This will authorize:

to release the complete medical records for _____
Patients Name Date of Birth

To: Eric D. Freeman, DO, F.A.A.P.M.R, C.I.M.E

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing: alcohol or drug abuse counseling or testing: and / or HIV testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person or entities as stated above. I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and if not revoked sooner in writing. I understand that I have the right to examine and copy the information to be disclosed unless deemed that such disclosure is not in my best interest. The medical records are disclosed under the provision of applicable New Jersey State and federal law.

To the receiving party of the information:

This information has been disclosed to you for the sole purpose stated in the consent. Any other use of this information without the expressed written consent of the patient is prohibited. This information has been protected by federal laws of confidentiality (42 C.F.R., Part 2).

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Parent / Guardian / Authorized Representative Signature: _____