GRACE MEDICAL GROUP, LLC

1600 ST. GEORGES AVENUE, RAHWAY, NJ 07065

TELEPHONE NUMBER: 848 236 5091

FAX NUMBER: 848 236 5092

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Patient Name: ____

Date of Birth: ____

Social Security Number: ____

I hereby authorize **GRACE MEDICAL GROUP, LLC,** to release or obtain medical records held in my name to/from the person or agency designated below. The records to be released or obtained may contain but are not limited to information related to emotional, or mental health/symptoms, HIV, substance or alcohol or substance abuse, and/or diagnoses and treatment for these conditions, including psychiatric hospitalizations and the use of psychiatric medications. I also authorize the release of information related to my medical and physical conditions, diagnoses, and treatments.

Medical/Psychiatric Records May Be Released to or Obtained from: (include name, address and phone number)

____

____

____

This Authorization to release or obtain medical records is to remain in effect for 90 days from the date indicated below and allows for exchange of medical information by telephone or other direct verbal communication in place of written communication.

______________________________ ________________________

PATIENT'S SIGNATURE DATE