Brick Psychiatric Services, Inc.

2640 Highway 70
Building 12, Suite 201
Manasquan, NJ 08736
P: 732-202-0622 F: 732-202-0620

Medical Release / Request

Name: _____

Date of Birth: _____/_____/_____ SS# _____

I hereby authorize Brick Psychiatric Services to release as well as obtain information from relevant parties (examples: physicians, hospitals, clinics) from _____ to _____.

Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

The following information from the medical records of the patient listed above is being requested / sent:

- ▢ Admission Assessment
- ▢ Discharge Summary
- ▢ Consultations
- ▢ Other: _____
- ▢ Laboratory Tests and Results
- ▢ Medications
- ▢ Treatment Plan

I understand that these medical records contain information pertaining to psychiatric counseling and/or testing, alcohol/drug abuse counseling and/or testing, along with HIV/AIDS diagnosis or testing. I do expressly and voluntarily authorize the disclosure of said medical records to the person(s) and/or entity as stated above. This authorization of consent will remain in effect indefinitely unless revoked (in writing), by the above patient (or by the patient's parent, legal guardian, or legally authorized agent) to our Medical Records Department. These medical records are being disclosed under the provisions of the applicable New Jersey State laws and United States Federal laws.

I CERTIFY that I have read (or have had read to me) the above statement and fully understand the content.

_____ _____

Signature of Patient / Parent / Guardian **Date**