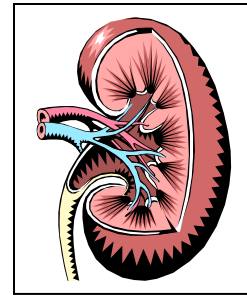


**Medicine & Nephrology Associates  
of Northwest Jersey, P.C.**

Main Office: 184 Mountain Avenue  
Hackettstown, N.J. 07840  
Phone: 908-684-4244 Fax: 908-684-4344

262 Route 10 West  
Succasunna, N.J. 07876  
Phone: 973-252-1522 Fax: 973-252-1422



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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: Medicine & Nephrology Associates of Northwest Jersey, P.C.

Address: 184 Mountain Avenue

City: Hackettstown State: N.J. Zip Code: 07840

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_  
\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

