John A. Infantolino MD,PC
5 Princeton Ave
Brick, N.J. 08724
(732) 840-0010
(732) 840 9770 fax

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ____________________ D.O.B. ______________
Address: ________________________________ __________
Telephone: _________________ Social Security #: ________________

I hereby authorize you to disclose my health information to:
The Office of John A. Infantolino MD
This authorization is limited to the following dates of treatment:

From: ___________ To: _______________

Information to be disclosed from
The office of___________________________________

Phone Number_________________________ **Fax**______________________

____ History and Physical
____ Reports
____ All Consultations
_____ Stress Test Results
_____ Most Recent EKG and Reports
_____ All EEG and reports
____ All Radiology Reports
_____ All Laboratory Reports
_____ All records
_____ Others ____________________

I understand that the information to be disclosed includes my identity, diagnosis, and treatment including Alcohol, Drugs,
Genetic Testing, Behavioral or Mental Health Services, Reproductive Rights, Sexually Transmitted and Infectious Diseases, AIDS and HIV information, as applicable.
It is my intent that the use of the information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated.
I understand that I have the right to revoke this authorization at any time. I understand in revoke this authorization, Imust do so in writing. I understand that this revocation will not apply to the extent that we have already taken action upon reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless

Patient Signature: ___________________________________ **Date:** ___________

If a legal representative, sign below and state relationship and authority to do so and attach document of authority.

Legal Representative: _________________ Date: __________