**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**
**(PROTECTED HEALTH INFORMATION)**

**Specific information to be released:**

☐ Verbal/Telephone/e-mail contact ☐ Other _____

☐ Summary of Treatment _____

☐ Office Notes _____

☐ Reports from labs or other outside studies _____

☐ I hereby authorize the following person(s) and/or organization(s) to release the above information to: Edward J. Bilotti, M.D. , Arnaldo Negron, M.D.., Neeta Kher, M.D., Benito Marty, M.D., Jacqueline Oshiver, LCSW, Lisa Bowman, LCSW, Marijayne Henry, LCSW, Robyn Klim, LCSW, Marion Pollack, LPC, Juliet Douglas, LCSW, Mitchell Douglas, LCW, Ellen Stem, LPC, Ann M. Dorocki, LCSW, and/or

Aroga Medical Associates, PC
188 Tamarack Circle
Skillman, New Jersey 08558
Phone: (609) 279-1339
Fax: (609) 279-1359

***- AND/OR -***

☐ I hereby authorize Edward J. Bilotti, M.D. , Arnaldo Negron, M.D.., Neeta Kher, M.D., Benito Marty, M.D., Jacqueline Oshiver, LCSW, Lisa Bowman, LCSW, Marijayne Henry, LCSW, Robyn Klim, LCSW, Marion Pollack, LPC, Juliet Douglas, LCSW, Mitchell Douglas, LCW, Ellen Stem, LPC, Ann M. Dorocki, LCSW, and/or Aroga Medical Associates, PC to release the above information to the following person(s) and/or organization(s):

Person(s) and/or Organization(s):

**PRIMARY CARE PHYSICIAN**
Name:_____
Address:_____
_____
Phone #:_____
Fax #_____

**THERAPIST**
Name:_____
Address_____
_____
Phone #_____
Fax #_____

**OTHER**
Name:_____
Address:_____
_____
Phone #:_____
Fax #_____

**OTHER**
Name:_____
Address_____
_____
Phone #_____
Fax #_____

I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue until termination of treatment unless another termination date is specified here: _____. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

**X**_____ _____
Signature of Patient (if 18 or older); Signature of Witness
Or Parent (if patient under 18);
Or Legal Guardian; or Health Care Agent

**X**_____ **X**___/___/___ _____ ___/___/___
Printed Name of Patient Date Printed Name of Witness Date
or Authorized Person

**X**____/____/____ _____
Patient's Date of Birth Title of Authorized Person (if applicable)