Permission Form to Send Medical Records

Advanced Laparoscopic Associates
TRUSTED CARE ENSURING HEALTHIER FUTURES

By signing this permission form, I allow Advanced Laparoscopic Associates to send a copy of my medical records to:

Name:_____

Street Address:_____

_____

City:_____ State:_____ Zip Code:_____

Medical Records to be sent (check one):

☐ All of my medical records

☐ Only the following medical records:_____

_____

Reason why I am giving permission to send medical records (check one):

☐ My new doctor needs them ☐ My lawyer needs them ☐ Insurance ☐ Personal

☐ Other reason:_____

I understand that:

- In accordance with HIPAA regulations, Advanced Laparoscopic Associates has up to 30 days to complete this request.
- This permission form is only good for one year from the date I sign it.
- I may cancel my permission at any time. I need to write you a letter to cancel permission. I need to bring or mail this letter to Advanced Laparoscopic Associates at 35 Plaza 81 Route 4 West Suite 401 Paramus, NJ 07652. I understand that Advanced Laparoscopic Associates may send my records before I cancel this permission. There is nothing that can be done about that.
- I do not need to sign this permission form to get medical treatment.
- I am allowed to get a copy of this permission form.
- I am allowed to look at my records or get a copy of my records before they are sent. The person who receives my records may not be required to protect my information and may share my information with others without my permission.
- I will be charged a copying fee.

Patient Name:_____

Patient Signature:_____ Date:_____

Special Medical Records

Some medical records have special protections. We need your specific permission to send the medical records listed below. Sign below to give permission to send these special medical records.

Please check the box next to the special medical records you give us permission to send.

☐ Drug and alcohol abuse records

☐ Mental health records

☐ HIV/AIDS records

☐ Sexual abuse/assault and domestic violence records

☐ Sexually-transmitted disease records

Patient Name:_____

Patient Signature:_____ Date:_____