MONMOUTH ENT & AESTHETICS

Consent to Release Information

I authorize Dr. Estelle Chang to release medical records to any health care providers participating in my medical care including but not limited to primary care physicians, referring physicians, hospitals, extended care/rehabilitation facilities, home health agencies, and ambulance services.

I also authorize Dr. Estelle Chang to release information regarding my medical health to the following people listed below.

This authorization also authorizes any other physician, hospital, laboratory, imaging center, pharmacy or other health care providers to release to Dr. Estelle Chang all medical records including but not limited to history and physical examination, progress notes, laboratory reports, imaging studies, audiograms, VNG/ENG reports, tympanograms, allergy tests, vial preparation information, immunotherapy schedules and any other information contained within my medical record. I give my consent to share my medical information with the appointed person/facility knowing that it contains private health information, and I authorize designated personnel to send it using the patient privacy laws that are required by the State of New Jersey. This authorization will automatically expire 60 days from the date of my signature.

(Initial) _____ I authorize Monmouth ENT & Aesthetics to download my medication history automatically from Pharmacies benefit managers.

Please indicate your agreement with this policy by signing below:

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Release health care information to the following persons/facilities:

List name and relationship to patient:

_____

_____

_____

_____

Disclaimer: Following State Law, this office is allowed 30 days to send records from the date of request but we will try to process it as quickly as possible. We apologized for any inconvenience caused.