# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
# ENDOCRINE CONSULTANTS OF MORRIS COUNTY

*Dr. Sheera Siegel | Dr. Anna Kissin*
*10 James Street, Suite 140, Florham Park, NJ 07960*
*973-665-8100 / 973-665-8097 Fax*

## SECTION 1 — PATIENT INFORMATION

| | |
|---|---|
| **Patient Full Name (Last, First, MI):** | **Date of Birth:** |

| | | | |
|---|---|---|---|
| **Current Address (Street):** | **City:** | **State:** | **ZIP:** |

| | |
|---|---|
| **Phone (Home / Cell):** | **Email Address (Optional):** |

## SECTION 2 — AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

*Complete this section only if the patient is a minor or the requestor is not the patient.*

| | |
|---|---|
| **Representative's Full Name:** | **Relationship to Patient:** |

| | |
|---|---|
| **Representative's Address:** | **Representative's Phone Number:** |

## SECTION 3 — RECIPIENT OF RECORDS (TO WHOM RECORDS WILL BE RELEASED)

| | |
|---|---|
| **Name of Individual or Organization:** | **Attention / Provider Name:** |

| | | | |
|---|---|---|---|
| **Phone Number:** | | **Fax Number:** | |

## SECTION 4 — AUTHORIZATION

*I, the undersigned, hereby authorize **Endocrine Consultants of Morris County** (Dr. Sheera Siegel and/or Dr. Anna Kissin) to use or disclose the protected health information described above to the individual or organization identified in Section 3.*

## SECTION 5 — SIGNATURE

| | |
|---|---|
| **Patient Signature or Authorized Representative:** | **Date:** |

| | |
|---|---|
| **Printed Name:** | **Relationship to Patient, if Authorized Representative:** |