KEITH SEIDENBERG, MD LLC
600 GODWIN AVENUE
MIDLAND PARK, NJ 07432
P: 201-447-9101 FAX: 201-447-9103

MEDICAL RECORD RELEASE FORM

TO: Office with Old Records:

DR. ____

ADDRESS: ____

FAX#:
____

Patient ______________________________ Date of Birth: __________________

Address ______________________________ SSN#: __________________

City/
State/Zip ______________________________

I hereby authorize and direct the release and transfer of my complete medical records for furtherance of my medical care to:

Keith Seidenberg, M.D.
600 Godwin Avenue
Midland Park, NJ 07432

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing and present my written revocation to the Privacy Officer at 600 Godwin Ave; Midland Park, NJ. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______________________________ __________________
Signature of Patient or Guardian Date