**Dr. Lisa Zimmermann MD**
**776 Shrewsbury Ave Suite 103**
**Tinton Falls NJ 07724**
**732-440-4782**

# HIPAA & Medical Records Release Form

I, _____, hereby authorize Dr. Zimmermann and staff to release my medical records to:

_____

Address: _____

Phone Number: _____ Fax Number: _____

The health information that may be disclosed is: all my past, present, and future periods of health care information.

**Acknowledgment**

I understand that the information disclosed under this authorization form may be subject to re-disclosure by the person(s) or facility receiving it. I have the right to refuse to sign this authorization form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient Name: _____ Date: _____

Patient Signature: _____

If the patient is a minor:

Legal Guardian Name: _____ Date: _____

Legal Guardian Signature: _____