Woodbridge Medical Associates, P.A.
1000 Route 9 North, Suite 302, Woodbridge, N.J. 07095
732/634-0036 ♦ Fax: 732/634-9182 ♦ www.woodbridgemed.com

Gastroenterology
Seth M. Webber, M.D.
Internal Medicine
Mary T. O'Donnell, M.D.
Lauren Maza, M.D.
Louis Friedman, D.O.
Physician Assistant
Luisa Lopez, PA-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **Woodbridge Medical Associates, P.A.**
Address: **1000 Route 9 North, Suite 302**
City: **Woodbridge** State: **N.J.** Zip Code: **07095**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All Healthcare Information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as definied by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphillis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD test results, HIV/AIDS test results, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified and that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Yes ☐ No I authorize the release of my Tuberculosis information.

☐ Yes ☐ No I authorize the release of any genetic information and/or Psychotherapy notes.

☐ Yes ☐ No I authorize the release of any activities where we receive money and/or marketing activities.

Patient Signature:_____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED