Princeton: 731 Alexander Road, Suite 202, Princeton, New Jersey 08540
Kendall Park: 3546 State Route 27 Kendall Park, New Jersey 08824

Phone: 732.737.7801 **Fax:** 877.623.3456
RESSTLLC@GMAIL.COM

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete this form to the best of your ability. **Please Print.**

Please Note: Copy Fee may be charged for medical records Todays Date: _______________

Patient Information

Patient Last Name: ____ First Name: _________________________MI: ________

Social Security Number: ______ - _____ - ___________ Date of Birth: ___________________________________ Sex: ☐ M ☐ F

Address: ____ City: ______________ State: ________ Zip: ____________

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: ______________________

Disclosing Facility

Above listed patient authorizes the following healthcare facility to make record disclosure:
Facility / Physician Name: ____ Phone: _________________________

Facility Address: ____Facility Fax: _________________________

City , State Zip Code: ____

Dates and Types of Information Requested

☐ Two (2) years prior from last date seen
☐ Dates (other): ____
☐ Specific information requested:_________________________________
☐ Other: ____

☐ Change of Insurance of Physician
☐ Continuation of care (E.G. VA Medical CTR)
☐ Referral

Receiving Facility

Above listed patient authorizes the following facility to receive record disclosure:
Respiratory & Sleep Specialists, LLC: **Dr. Bajaj** ☐ **Dr. Khan** ☐ **Dr. Koganti** ☐ **Dr. Youssef** ☐
Other ☐ **:** ____

Facility Address: ____Facility Phone: ________________________

City , State Zip Code: ____ Facility Fax: _________________________

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE MAY BE CHARGED on all balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

Signature: ____ Date: _________________________