Authorization for Release of Medical Records

Patient's Name:_____ D.O.B._____

Address:_____Phone: _____

I hereby authorize **Dr. Neelam Sell** and **THE MILESTONES CENTER, LLC,** to release my medical records in accordance with this authorization.

Please release my medical records, as set forth below, to:

Name:_____Organization:_____

Address:_____

_____

Please indicate the information or types of information to be released (including dates if necessary). Please indicate "ALL" if you would like your entire record to be released:

_____

_____

I understand that the information in my medical record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome** (**AIDS)**. This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

_____ _____

Patient or Legal Representative Date

_____

Representative's authority to act on behalf of
Individual (Parent or guardian)

Please send the signed form to the Milestone Center, LLC at:
Mail: 65 Mechanic Street, Ste L3, Red Bank NJ 07701
Email: themilestonescenter@gmail.com