Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME_____ **DOB**_____TELEPHONE#_____

Address_____City_____State_____Zip_____

I hereby authorize:(FROM)

FACILITY/NAME_____**FAX#**_____**PHONE#**_____
Address_____City_____State_____Zip_____

To use or disclose (release) my protected health information as indicated below to:(T0)

FACILITY/NAME_____**FAX #**_____**PHONE#**_____

Address_____City_____State_____Zip_____

Purpose of Disclosure: (☐anging Physicians S☐cond Opinion (☐ntinuing Care L☐al I☐urance S☐hool

INFORMATION TO BE RELEASED:

History & Physical/Office Notes DOS: _____to_____ LabsDOS:_____to_____

DIAGNOSTIC STUDY: DOS_____to_____ConsultationDOS:_____to_____ Hospital DOS:_____to_____

Cardiac DOS_____to_____Immunizations DOS:_____to_____

- I understand that HIV related information, Mental Health Information and/or Drug/Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ***DO NOT RELEASE*** _____

  _____
- I understand that this authentication will expire two years from my last date of service. A photocopy of this form will be considered as valid as the original.
- I understand that I may revoke this authorization at any time by notifying **Sandra Privetera**, in writing at **4 HartfordDrive, Suite 1, Tinton Falls, NJ, 07701**, and that this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- My health care and payment for my health care will not be affected if I do not sign this form.
- I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
- I understand that I will get a copy of this form after I sign it, if requested.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ OR _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____ _____
Records Received By Date Relationship to Patient

FOR OFFICE USE ONLY WHEN PICKED UP IN PERSON

Date Request Filled_____ By_____ ID Presented_____ Fee_____

REVISED 04/18/2023