

Hunterdon Family Practice & Obstetrics

1100 Wescott Drive, Suite 101
Flemington, New Jersey 08822

TEL: (908) 788-6535

FAX: (908) 788-6536

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____, authorize the use and/or disclosure of my protected health information as described below.

The individual or organization below is authorized to use and/or disclose my protected health information:

Name of Individual /Organization: _____

Address: _____

Phone: _____ Fax: _____

This information may be released to the following individual or organization.

Name of Individual/Organization: _____

Address: _____

The type and amount of information to be used or disclosed is as follows:

This authorization may include disclosure of information relating to genetic testing, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral/mental health information, psychotherapy notes, treatment for alcohol and drug abuse and tuberculosis, only if I place my initials on the appropriate line below:

- _____ Genetic Testing
- _____ STDs
- _____ AIDS/HIV
- _____ Behavioral/Mental Health Information
- _____ Psychotherapy Notes
- _____ Alcohol/Drug Abuse
- _____ Tuberculosis

The information is being used and/or disclosed for the following purposes:

This authorization will expire on the following date, event, or condition:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing at the address above. I understand that a revocation is not effective to the extent that action has already been taken based on this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this use and/or disclosure.

I understand that the information disclosed under this authorization might be re-disclosed by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations. I understand that I have the right to receive a copy of this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority to Sign for Patient