JMD Family Practice
2 Kings Court
Suite 203
Flemington, NJ 08822
Phone: 908.751.5439 / Fax: 908.751.5478

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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

The individual or organization below is authorized to use 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: _____

Phone: _____ Fax: _____

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 listed below. 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 Designated Representative Date

_____

Name of Patient or Designated Representative

_____

Description of Representative's Authority to Sign for Patient