Authorization for Use or Disclosure of Protected Health Information

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. **I,** _____ **, authorize the disclosure of information from my medical record.**
(Name of Patient)
Birthdate: _____ **SSN (Last 4 digits): XXX-XX-** _____

II.

The information is to be disclosed by:	**And is to be provided/sent to:**
NAME OF FACILITY _____	*NAME OF PERSON/ORGANIZATION/FACILITY* _____ **Porzio, Bromberg & Newman, P.C.**
ADDRESS _____	*ADDRESS* **5 Sylvan Way, Suite 110** **Post Office Box 218**
CITY, STATE, ZIP _____	*CITY, STATE, ZIP* **Parsippany, NJ 07054**

III. **Purpose or need for this disclosure is:**

☐ Continued Treatment ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other _____

IV. **Information to be disclosed from my medical record:** ***(Check appropriate box(es))***

☐ Only information related to (specify) _____

_____

☐ Only for dates of service from _____ to _____
☐ Other (specify) (ex: radiology, billing, etc.) _____
☐ Entire Record

V. **If you would like any of the following sensitive information disclosed, check the applicable box(es) below:**

☐ Alcohol/Drug Abuse Treatment/Referral ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Genetic Testing
☐ HIV/AIDS Testing & Treatment ☐ Sexual & Reproductive Health

VI. I understand that by signing this authorization, my Treatment, Payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

VII. I understand that the information disclosed may be subject to redisclosure by the person or entity receiving it and would then no longer be protected by federal privacy regulations.

VIII. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

IX. I authorize you to speak to any attorneys, agents, or other employees of Porzio, Bromberg & Newman regarding my medical care, including your treatment of me, your diagnoses, prognosis, need for future treatment, and the causes of my various medical conditions.

X. This authorization expires on _____, OR upon the following event:

_____

If no date or event is specified, the authorization will automatically expire one (1) year from the signature date.

_____ _____
SIGNATURE OF PATIENT *DATE*

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE & RELATIONSHIP TO PATIENT *DATE*

_____ _____
SIGNATURE OF WITNESS (if signature of patient is a thumbprint or mark) *DATE*