Colonia Office
795 Inman Ave
Colonia, NJ 07067
Ph: (732) 396-0700
Fax: (732) 396-0701

Plainfield Office
120 W 7th St. Ste 203
Plainfield, NJ 07060
Ph: (908) 757-8687
Fax: (908) 757-8685

Authorization to Release Protected Health Information (General)

Patient Name _____ Date of Birth _____

Name of Legal Representative (if applicable) _____ Relationship _____

I hereby authorize you to use or disclose **ONLY** the following health care information:
(please initial all that apply):

Initials	Information to be released
	All my health information maintained by the practice (except as not authorized to release).
	My health information related to drug abuse.
	My health information related to alcohol abuse.
	My health information related to HIV/AIDS.
	My health information related to Sexually Transmitted Diseases (STDs)
	My health information related to Genetic Information
	My health information related to behavioral/mental health, and psychological or psychiatric conditions ***EXCEPT Psychotherapy Notes, as is defined by the Health Insurance Portability and Accountability Act (HIPAA) 45 CFR 164.501. Psychotherapy notes require a separate authorization.***
	Psychotherapy notes, as is defined by the HIPAA 45 CFR 164.501. ***Psychotherapy notes require a separate authorization pursuant to HIPAA 45 CFR 164.508(b)(3).***
	My health information relating to the following treatment or condition
	Other Conditions as Listed:
	My health information for the date(s) [please specify]:
	My entire health record (except as not authorized to release)

I understand that that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, reproductive rights, infectious disease, genetic testing, and/or treatment for alcohol and/or drug abuse. **THIS AUTHORIZATION DOES NOT AUTHORIZE DISCLOSURE OF THE SAME** unless I have specifically given permission in the check box(s) above for release and signed this authorization form.

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The designated health information noted above may be disclosed to:

Name (or title) and organization: _____

Address: _____

City: _____State: _____ Zip: _____

This information and authorization may be disclosed and/or used ONLY for the following reason(s):

_____

_____

This authorization expires: Date: _____ (If a date is not specified, this authorization will expire 6 months from the date signed)

A **photocopy** of this authorization shall be considered as effective and valid as the original.

Right to Revoke Authorization

I understand that I may revoke this authorization in writing at any time. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The revocation letter must be signed by me or on my behalf by my legally authorized representative.

Once this office discloses the above designated health information, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

_____ _____
Patient or Legally Authorized Individual Signature **Date**

_____
Printed Name if Signed on Behalf of the Patient

_____
Relationship (parent, legal guardian, personal representative, etc.)

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.