KENILWORTH PRIMARY CARE

DR. BHAVANI JEEREDDY

66 SOUTH 21ST STREET, KENILWORTH, NJ 07033

(908) 276-9595

Authorization for Health Information Disclosure

This form complies with HIPPA privacy rule

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____city_____ State_____ Zip code_____

I hereby authorize: Name: _____ Address: _____

Phone: _____Fax:_____

(Name of the Physician`s office/medical practice disclosing information)

Recipient Information

Please disclose the following protected health information to Dr Bhavani Jeereddy located at 66 South 21st Street, Kenilworth, NJ 07033

Please indicate the types of information to be disclosed:

_____

_____

Specify dates (or date ranges) if applicable: _____

This request is for the purpose of _____

I understand that I have right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy offices of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 6 months or on the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and or copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose the information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL, DO NOT RELEASE _____.

_____

_____

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Signature of Patient/Authorized Representative

Date