Advanced Obstetrics & Gynecology, LLC

4 Walter E. Foran Boulevard, Suite 302, Flemington, NJ 08822
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Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ **DOB:** ____ / ____ / _____
Phone: (_____) _____ - _____ □ Home □ Work □ Cell
Address: _____
City/Town: _____ State: _____ Zip Code: _____

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

The individual or organization below is authorized to use 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.

The information is being used and/or disclosed for the following purposes**:**
□ Referral to Specialist □ Leaving the Practice □ Moving out of the Area □ Personal Use
□ Other: _____
_____
_____

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

Advanced Obstetrics & Gynecology, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language Assistance Available:

Español (Spanish) | 繁體中文 (Chinese) | Tiếng Việt (Vietnamese) | 한국어 (Korean) | हिंदी (Hindi) اردو (Urdu) | Tagalog (Tagalog-Filipino) | Русский (Russian) | العربية (Arabic) | Kreyòl Ayisyen (Haitian Creole) Français (French) | Polski (Polish) | Português (Portuguese) | Italiano (Italian) | ગુજરાતી (Gujarati)