Advanced Obstetrics & Gynecology, LLC

4 Walter E. Foran Boulevard, Suite 302, Flemington, NJ 08822

Phone: (908) 806-0080 Fax: (908) 806-8570

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 *only if I place my initials* on the appropriate line below:

_____ AIDS/HIV

_____ Alcohol/Drug Abuse

_____ Behavioral/Mental Health Information

_____ Genetic Testing

_____ Psychotherapy Notes

_____ STDs

_____ 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) | □□□ (Korean) | ह िंदी (Hindi)اردو) Urdu) |
Tagalog (Tagalog-Filipino) | Русский (Russian) | العربية) Arabic) | Kreyòl Ayisyen (Haitian Creole)Français (French) |
Polski (Polish) | Português (Portuguese) | Italiano (Italian) | ગુજ રાતી (Gujarati)