Teaneck Gastroenterology Associates, PA

1086 Teaneck Rd, Suite 4C, Teaneck, NJ 07666
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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form provides authorization to **Teaneck Gastroenterology Associates, PA ("The Practice")** to use or disclose certain personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I, _____ (date of birth)_____ authorize THE PRACTICE to disclose to/obtain from:

_____

_____

_____

The following information: _____

_____

I understand that if my records contain information about HIV/AIDS status, I authorize THE PRACTICE to release such information as part of my medical record.

Purpose of Information to be Disclosed (if you have requested the use of disclosure of the information but do not, or elect not to, provide a statement of the purpose , the purpose shall be stated as "at the request of the individual"):__

_____

This authorization shall expire _____ days from the date of this request or the occurrence of the following:_____

_____

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to Practice Privacy Officer, Terri Newhouse, at 1086 Teaneck Road, Suite 4C, Teaneck, NJ 07666.

I understand that a revocation is not effective to the extent that THE PRACTICE has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that THE PRACTICE will not condition my treatment on whether I provide authorization for the requested use or disclosure as to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this information to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization, if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority