AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Patient Information

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ Zip: _____ SS#: _____

I hereby authorize: M. LUPOVICI, M.D., 254 Princeton-Hightstown Rd. East Windsor, NJ 08520
(Name of physician's office disclosing information)

Requestor/Recipient Information

Please disclose the following protected health information to:

_____

_____

Please indicate the information or types of information to be disclosed:

_____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer 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 six 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 authorizing this disclosure is voluntary. 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 this 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 _____.

_____ _____
Signature of Patient or Authorized Representative Date