HUDSON COUNTY PRIMARY CARE

JEFFREY R. PAPPERT, MD

Diplomate, American Board of Internal Medicine

377 Jersey Avenue, Suite 590 ✦ Jersey City, NJ 07302 ✦ Tel: 201.763.6313 ✦ Fax: 201.763.6062

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

I hereby authorize **H**UDSON **C**OUNTY **P**RIMARY CARE, LLC to use or disclose the health information described below. I understand the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Information may be released to the following person(s)/facility:

☐ Myself – how may we contact you? ☐ home phone ☐ cell phone ☐ work phone

– can we leave a message on your answering machine? ☐ yes ☐ no

☐ Other Person(s)/Facility:

Name of recipient(s): _____ _____

Relationship to patient: _____ _____

Telephone of recipient: _____ _____

Address of recipient: _____ _____

_____ _____

_____ _____

The specific information to be used or disclosed include:

☐ all medical records	☐ pathology reports	☐ history & physical
☐ office progress notes	☐ imaging results	☐ pathology reports
☐ laboratory reports	☐ EKGs	☐ consultation reports
☐ operative reports	☐ billing records	☐ other: _____

SIGNATURE: _____ **DATE:** _____

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The purpose of the disclosure/release is for:

☐ personal/family use ☐ change of physician ☐ school ☐ consultation request

☐ insurance purposes ☐ workers' comp ☐ legal ☐ other: _____

Please release information for treatment period:

☐ From: _____ To: _____

☐ All dates of treatment

This authorization shall expire (please ✓ one):

☐ **ONE YEAR** from the date signed below or

☐ Other (please specify): _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released.
- information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my refusal cannot be used as a reason for denial of services or benefits.

☐ I acknowledge that I received a copy of **HUDSON COUNTY PRIMARY CARE'S HIPAA NOTICE OF PRIVACY PRACTICES**, which include my rights regarding how medical information can be used and disclosed.

SIGNATURE: _____ **DATE:** _____