

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 HUDSON COUNTY PRIMARY 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:

- | | | |
|--|--|---|
| <input type="checkbox"/> all medical records | <input type="checkbox"/> pathology reports | <input type="checkbox"/> history & physical |
| <input type="checkbox"/> office progress notes | <input type="checkbox"/> imaging results | <input type="checkbox"/> pathology reports |
| <input type="checkbox"/> laboratory reports | <input type="checkbox"/> EKGs | <input type="checkbox"/> consultation reports |
| <input type="checkbox"/> operative reports | <input type="checkbox"/> billing records | <input type="checkbox"/> 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:** _____