Premier Family Medicine
Authorization for Use and Disclosure of Protected health Information

Patient Name:_____
Date of Birth: _____Phone: _____
Address: _____
City: _____State: _____ Zip: _____

I, _____, authorize the use or disclousre of the my protected health information as described below.

The Physician/Organization: _____
Address: _____
Phone: _____ Fax: _____

This information may be releaased to the following Individual/Organization:

Jonathan Wierzbicki, MD
Premier Family Medicine
5 Walter Foran Blvd, Suite 4000, Flemington NJ 08822
Phone: 908-824-7179 Fax: 908-824-7684

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 trasmitted 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 appropropriate line below:

___Genetic Testing _____ STDs _____AIDS/HIV
___Behavioral/Mental Health Information
___Psychotherapy Notes _____Alcohol/Drug Abuse
___Tuberculosis

The information is being used and/or disclosed for the following purposes:

_____

_____.

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