DRS. HEYMANN, MANDERS & GREEN, LLC.
3 Cooper Plaza, Suite 211
Camden, New Jersey 08103
Phone #: 856-342-2381 • Fax #: 856-968-8454

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION
THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY RULE

By signing this authorization, I authorize HEYMANN, MANDERS, & GREEN, LLC. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below:

_____

_____

_____

Patient Name: _____

D.O.B.: _____

Approximate Date(s) of Treatment: _____

Information to be disclosed:

____ Any and all information concerning my treatment at this office

____ Biopsy reports

____ Other: _____

Purpose(s) for disclosure: ____ At the request of the patient

____ Other _____

This authorization is good for 12 months from the date signed below my signature.

I understand that I may revoke this authorization at any time, even if it has not expired by giving written notice to the privacy officer. My written revocation must be submitted to HEYMANN, MANDERS, & GREEN, LLC's *Privacy Officer at 3 Cooper Plaza, Ste. 211, Camden, NJ 08103.*

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA *Privacy Rule.*

_____ _____
Patient Signature *Date*

_____ _____
Authorized Representative *Date*

_____ _____
Print Name *Relationship to Patient*

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PATIENT AUTHORIZATION FOR PRACTICE TO RECEIVE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize the following office, facility or institution to disclose certain protected information (PHI) about me to the party listed below:

DRS. HEYMANN, MANDERS & GREEN, LLC.
3 Cooper Plaza, Suite 211
Camden, New Jersey 08103
Phone # (856) 342-2381
Fax # (856) 968-8454

Patient Name: _____ D.O.B. _____

Doctor's Office: _____

Address: _____

Fax Number: _____

Information to be disclosed:

____ Any and all information concerning my treatment at your office

____ Biopsy reports

____ Other: _____

Purpose(s) for disclosure: ____ At the request of the patient

____ At the request of the physician

____ Other _____

This authorization is good for 12 months from the date signed below my signature.

I understand that I may revoke this authorization at any time, even if it has not expired by giving written notice to the privacy officer. My written revocation must be submitted to HEYMANN, MANDERS, & GREEN, LLC's Privacy Officer at 3 Cooper Plaza, Ste. 211, Camden, NJ 08103.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

_____ _____
Patient Signature *Date*

_____ _____
Authorized Representative *Date*

_____ _____
Print Name *Relationship to Patient*