

DRS. HEYMANN, MANDERS & GREEN, LLC.

100 Brick Road, Suite 306

Marlton, New Jersey 08053

Phone #: 856-596-0111 • Fax #: 856-596-7194

**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.

100 Brick Road, Suite 306

Marlton, New Jersey 08053

Phone # (856) 596-0111

Fax # (856) 596-7194

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 100 Brick Road, Ste. 306, Marlton, NJ 08053.

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 HIPPA Privacy Rule.

Patient Signature

Date

Authorized Representative

Date

Print Name

Relationship to Patient