HEYMANN, MANDERS & GREEN, LLC.

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY RULES

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

Obtain from:	Release to:
_____	_____
_____	_____
_____	_____

Patient Name: _____

Date of Birth: _____

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

_____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, Attn: Privacy Officer, 100 Brick Road, Suite 306, Marlton, NJ 08053.

When my information is used or disclosed, pursuant to this authorization, it may be subject to redisclosure by the recipients and may no longer be protected by the Federal HIPAA Privacy Rule.

_____ _____

Patient Signature *Date*

_____ _____

Authorized Representative *Date*

_____ _____

Print Name *Relationship to Patient*

Revised 1/2/19