HIPPA - AUTHORIZATION TO DISCLOSE INFORMATION

Individual's Name (Print):_____
Date of Birth:_____Social Security No.:_____
Address: _____ Telephone:_____

I hereby give authority to _____ to disclose any and all information requested to my lawyer:

Law Offices of James C. DeZao, P.A.
322 Route 46 West, Suite 120
Parsippany, NJ 07054
P: (973) 808-8900 F: (973) 808-8648

The information to be disclosed to and used by the above is for the following purposes:
-Personal injury occurring on _____

Information to be disclosed:

☐ Emergency Room Record	☐ Abstract	☐ Progress Notes
☐ Operative & Pathological Report	☐ Billing Info	☐ Intake
☐ Discharge Summary	☐ Labs/Diagnostic Tests	☐ Complete Records
☐ Consultations	☐ Nursing Notes	☐ Other: _____

This authorization expires on _____ or one (1) year from the date signed, below, whichever is less. I understand that upon this expiration date, the aforementioned provider will no longer provide my information to the above stated representative and that if I wish for this person to continue to receive information, I must execute another authorization. I understand that if the above-named person is not a health care provider or part of a health plan covered by federal privacy regulations, my **health** information may be re-disclosed by the person(s). I have named above and will no longer be protected by these regulations. However, the person(s) named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I understand that if I refuse to sign this form, my information will not be disclosed to the person(s) authorized above. I understand I may revoke this authorization at any time, in writing. The written request to revoke this authorization must be provided to the New Jersey Health Information Management Department. The revocation will be effective on the date that the aforementioned representative, who received this Authorization receives the revocation. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules/laws.

Signature of Individual:_____
Date of Signature: _____**Telephone Number:_____**

If legal representative (if individual is a minor, parent/guardian sign below), sign below and state relationship and authority to do so and attach the document of authority.

Signature of Individual:_____ **Date:** _____
Relationship: _____**Telephone Number:_____**

Copy of Valid Appointment of Guardianship or Power of Attorney must be attached.
Witness Signature (if applicable):_____ Signed and Sealed this_____