NOTICE TO RELEASE PRIVATE HEALTH INFORMATION TO FAMILY MEMBER(S) OR REPRESENTATIVE(S) OF PATIENT

PATIENT NAME & DOB: _____
ADDRESS: _____
TELEPHONE #: _____

SPECIFY INFORMATION TO BE DISCLOSED:

_____

_____

RECIPIENT(S) HEALTH INFORMATION MAY BE DISCLOSED TO:

_____

_____

ADDRESS OF THE RECIPIENT(S) WHERE MY HEALTH INFORMATION SHOULD BE DELIVERED:

_____

_____

TERM: THIS AUTHORIZATION MAY REMAIN IN EFFECT UNTIL: _____

By my signature below, I hereby authorize The Minniti Center to use or disclose to the recipient(s) my health information and understand that once my health information is disclosed, The Minniti Center cannot guarantee that the recipient(s) will not redisclose my information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclose of my health information.

I understand that The Minniti Center will, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of The Minniti Center's treatment of me; except, however, if my treatment at The Minniti Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case The Minniti Center may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term indicated above expires or I provide a written notice of the revocation to The Minniti Center at the address listed below. The revocation will be effective immediately upon The Minniti Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by The Minniti Center in reliance on this Authorization before it received my written notice of revocation.

I may contact The Minniti Center's practice manager, Linda Burke, by mail at 174 Democrat Road, Mickleton, NJ 08056 and I may contact her by telephone at 856-423-0754.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize The Minniti Center to use or disclose my health information in the manner described above.

_____ _____
(Signature of Patient) (Date)

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
(Signature of Personal Representative) (Description of Authority) (Date)