NORTHERN NEW JERSEY
EYE INSTITUTE

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____
Address: _____
Social Security #: _____ Telephone: _____

Northern New Jersey Eye Institute is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Northern New Jersey Eye Institute to disclose my protected health information as described on this form to the recipients listed below. I understand that when the 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 health information. I further understand that I retain the right to revoke this authorization if done so in writing.

Please check the type of information to be released:

_____ Complete Health Record
_____ Complete Billing Record
_____ Laboratory Results

I, the undersigned, authorize the above referenced provider to release information to: (please circle)
Spouse Children Other

Name/Relationship: _____

Northern New Jersey Eye Institute can leave medical information on my home answering machine? (please initial on line)

_____ Yes _____No

Drug and/or Alcohol Abuse, and/or Psychiatric and/or HIV-AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment and/or other sensitive information, and I agree to its release as noted above.

Patient's or Guardian Signature: _____Date: _____

Authorization to sign if not the patient: _____
Name/Relationship