NJ Advanced Surgical Solutions

RELEASE OF MEDICAL INFORMATION REQUEST

Patient medical records are CONFIDENTIAL. Protecting your privacy is very important to us, therefore, according to new federal regulations; we may not discuss or release information to anyone but the patient unless authorized by the patient to do so. We want to make sure that you receive information that is necessary to assist us in providing quality care and service. Please complete the information below so that we may better serve you and your needs. This authorization will stay in effect until written notice is received from you to either cancel or amend.

Patient Name: _____ Date of Birth: _____ SS# _____

I give this office permission to contact me by (initial all that apply):

_____ Telephone my home _____ Leave messages on my home answering machine

_____ Telephone my work _____ Leave messages on my voicemail at work

_____ Telephone my cell phone _____ Leave messages on my cell phone

If you would like us to discuss your information with anyone other than yourself, please write his or her name and relationship (i.e. spouse, children, friend, etc) below:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

Our practice is dedicated to maintaining the privacy of your confidential, protected health information (PHI). In conducting our business we create records regarding your health status and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which this practice may use or disclose health information about you. It also describes your rights and our obligations regarding the use and disclosure of that information.

By signing below you acknowledge that you have received our Notice of Privacy Practices.

RESPONSIBLE PARTY: _____ RELATION TO PATIENT: _____

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE _____