

**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH
INFORMATION**

Patient Name:

Date of Birth:

Previous Name:

SSN:

By signing this form, I hereby authorize:

to disclose the health information described below to **Law Offices of Charles A. Cerussi, P.C., 600 Broad St. Suite C, Shrewsbury, NJ 07702-4117.**

Check all that apply:

- All health information
- Health information relating to the following treatment or condition:
- Health information for the date(s):
- Other specific description:

Reason for This Authorization:

- At my request
- Other:
- _____ has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date:_____

I understand that any disclosure or information may be subject to re-disclosure by the recipient and may no longer be protected by federal court state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment for drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE_____.

Patient/Legally Authorized Representative

Date

Printed Name

Relationship to Patient