HACKETTSTOWN PEDIATRICS, LLC
PEDIATRIC AND ADOLESCENT MEDICINE
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4C DOCTORS PARK
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This form must be completed for all authorizations.

I hereby authorize the use and disclosure of my individual identifiable health information as described below, I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name:_____ Date of Birth:_____

Persons/Organizations authorized to use disclosed information: Hackettstown Pediatrics, LLC.

The patient or patient's representative must read the following statement:

I understand that this authorization will expire on _____

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that I may get a copy of this form after I sign it.

I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on actions the Practice has already taken in reliance on this authorization.

Signature of patient or patient's representative Date

Printed Name of patient or representative Relationship to patient