NORTH DOVER OB-GYN ASSOCIATES
222 Oak Avenue • Toms River, NJ 08753-3326
Phone 732.914.1919 Fax 732.914.0725

Patient Authorization for Practice to Release Protected Health Information To Third Parties

By signing this authorization, I authorize:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

to disclose certain protected health information (PHI) about me to:
North Dover OB/GYN Associates
222 Oak Ave.
Toms River, NJ 08753

Information requested: Treatment Dates: From _____ to _____

- ☐ Medical History & Examinations
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Other (specify) _____

This authorization will expire _____.
(Expiration date 6 months from today's date)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that North Dover OB/GYN Associates has acted in reliance upon this authorization. My written revocation must be submitted to North Dover OB/GYN Associate's Privacy Officer at 222 Oak Ave., Toms River, NJ 08753.
Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Patient's Social Security Number

_____ _____ _____
Print Name of Patient or Legal Guardian Patient's Date of Birth Today's Date