PROSPECT OBGYN

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Telephone: (201) 880-4949
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HIPAA Authorization for Verbal Release of Protected Health Information

I, _____ give permission to: Prospect OBGYN and its employees. To Release the information regarding appointments dates/times and protected health information, including; but not limited to, insurance, address, phone numbers, test results, health care information, and treatment to the following:

If you do not wish to include anyone on your HIPAA form please mark the line(s) with an "X" and sign the bottom of the page.

Name of Person: _____ Relationship to Patient: _____

Name of Person: _____ Relationship to Patient: _____

I understand that:

I may revoke this authorization at any time, in writing. My revocation may not apply to the information already retained, used or disclosed in response to this authorization.
Unless the purpose of this authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon the signing of this Authorization.
Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
The information Authorized for release may include information which may indicate the presence of a communicable disease or non-communicable disease.
The information authorized for verbal release may also include protected health information related to mental health.
It is my responsibility to update the above contact names and numbers, in case they should change. I must do so by contacting Prospect OBGYN and its' employees requesting a new form to be filled via:

- **Mail:** 80 route 4 East, Paramus Nj 07652. The Atrium - Second floor. Suite 230A
- **Fax:** 973-852-1747

_____ _____
Patient Signature Date