

Miracles in Communication of Northern New Jersey, LLC

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Patient Disclosure Authorization Form

Patient Name: _____

Date of Birth: ____/____/____

I authorize disclosure of protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below, in addition to information being disclosed as referenced in the *Notice of Privacy Practices*)

Specific description of information to be used or disclosed:

Reason for requested use or disclosure:

Names of the professionals at this practice authorized to discuss my information:

Names of the people to whom this practice will give my information:

This authorization will expire on the following (please check one or both boxes):

Date: ____/____/____

Event (Relating to patient or the purpose of disclosure): _____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on the consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to his authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature: _____

Relationship to patient (if signed by a personal representative, parent, or guardian or patient)
