

EXPRESSCARE HEALTH, LLC
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize ExpressCare Health, LLC, and/or its administrative and clinical staff, to disclose the Protected Health Information –

FOR: Patient Name: _____

Address: _____

Date of Service: _____

Location of Service: ExpressCare of Brick ExpressCare of Neptune ExpressCare of Woodbridge
(Please circle one.)

TO: Recipient Name: _____

Address: _____

I am authorizing this Protected Health Information to be disclosed for the following purpose(s):

This authorization for the disclosure of Protected Health Information expires: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

ExpressCare Medical Records
2540 Route 130, North
Suite 118
Cranbury, NJ 08512

I understand that a revocation is not effective to the extent that the Recipient I designated above may have relied on the disclosed Protected Health Information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information disclosed pursuant to this authorization may be disclosed by the Recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating Protected Health Information for disclosure to a third party.

The disclosure requested under this authorization may result in direct or indirect remuneration to my physician from a third party.

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Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Note – Please mail this Authorization for Disclosure of Protected Health Information form to:

ExpressCare Medical Records
8004 H Lincoln Drive West
Marlton, New Jersey 08053