Somerset Surgical Associates

Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ Date of Birth: ___/____/___

I hereby authorize Somerset Surgical Associates, LLC, 30 Rehill Avenue, Suite 3400, Somerville, NJ 08876

to use and/or disclose the Protected Health Information described below to (Entity to whom information is being released): _____
for the purpose(s) of (specify the reason that this information is being released):

_____

Protected Health Information (Identify specific information to be released):

_____

_____

Dates of care included: _____ to _____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that Somerset Surgical Associates, LLC will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Somerset Surgical Associates, LLC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be signed to federal or state law protecting its confidentiality.

Sarah Bryczkowski, MD, FACS ● Obi J Imegwu, MD, FACS
Thangamani Seenivasan, MD, FACS ● William M Sugarmann, MD, FACS
30 Rehill Avenue, Suite 3400, Somerville, NJ 08876
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EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____, or the following event:

_____

Somerset Surgical Associates, LLC, shall supply a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

New Jersey state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize Somerset Surgical Associates, LLC to release any information that may be in my medical records regarding my HIV status, records of Mental Health care and treatment, records of Substance Abuse care and treatment, and records of Sexually Transmitted Disease care and treatment.

___/___/___	_____	_____
Today's Date	Signature of individual patient or representative	Authority or relationship of Representative

FAX OR MAIL THIS FORM BACK TO: **Somerset Surgical Associates, LLC**
Attn: Medical Records
30 Rehill Ave, Suite 3400
Somerville, NJ 08876

Fax #: 908-927-2990

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