**All Your Family Needs Primary Care LLC**
**Kerri Murry, FNP**
164 River Road
Annandale, NJ 08801

Tel: 908.323.2643 Fax: 908.323.2648
www.ayfnpc.com

**Patient's Name:**
___________________________________

**Date of Birth:** _______________________
MM/DD/YYYY

# Authorization for Use and Disclosure of Protected Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

***I authorize the following using or disclosing party:***

Name of Individual/Organization:_____________________________________________________________

Address:__________________________________________________________________________________

Phone: ____________________________________ Fax: ________________________________

***To use or disclose:***

- ❑ All my health information / medical record
- ❑ My health information related to the following treatment or condition:
  ____________________________________________________________________________
- ❑ This authorization will exclude: (check all that apply)
  - ❍ Genetic Testing
  - ❍ Sexually Transmitted Infections
  - ❍ Behavioral / Mental Health
  - ❍ Psychotherapy Notes
  - ❍ HIV/AIDS
  - ❍ Alcohol / Drug Abuse
  - ❍ Tuberculosis
  - ❍ Other:____________________________________

***The above party may disclose this health information to:***

**ALL YOUR FAMILY NEEDS PRIMARY CARE, LLC**
**KERRI MURRY, FNP**
164 River Road, Annandale NJ 08801
Phone: 908.323.2643 :: **Fax Records to: 908.323.2648**

**All Your Family Needs Primary Care LLC**
**Kerri Murry, FNP**
164 River Road
Annandale, NJ 08801

Tel: 908.323.2643 Fax: 908.323.2648
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**Patient's Name:** ____________________________________

**Date of Birth:** ________________________
MM/DD/YYYY

***The purpose of this authorization is:*** *(check all that apply)*

- ❍ Continuation of Care
- ❍ Transfer of Care
- ❍ Other:__________________________________________________

***This authorization will expire on the following date, event or condition:***

_____________________________________________________________________

***My Rights:***

I understand that I have a right to revoke this authorization at any time except where uses or disclosures have already been made based upon my original permission. I understand that if I revoke this authorization I must do so in writing at the address of the provider that I have authorized and identified as the disclosing party.

I understand that the disclosure of this health information is voluntary. I can refuse to sign this authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my authorization of this use and/or disclosure.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards and implementing regulations.

I understand that I have a right to request a copy of this authorization.

*Signature* of Patient or Personal Representative: ________________________________________________________

Today's Date: ___________________________

*Printed* Name of Patient or Personal Representative:______________________________________________________

*Description/Relationship* of Personal Representative (if not signed by patient):________________________________

Patient's Address: __________________________________________________________________________________
STREET CITY STATE, ZIP

Patient's Phone: ____________________________________________________