Phone: 973-434-5030
Fax: 800-854-3471
contactus@telenphealth.com
Corporate Office: Dallas, Texas
Services Rendered in: New Jersey, Massachusetts , Connecticut, & Washington

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

If you want TeleNP Health PLLC to receive and/or share information about you with another individual or organization, please make sure that you fill out all of the sections below. This will tell us what information you authorize us to share and who to share it with. If you leave any sections blank your permission will not be valid.

Patient's First and Last Name * _____

Date of Birth * _____

Email _____

Date * _____

Please note the following regarding your authorization:

1. This authorization shall be effective for 12 months following the date of your signature. However, you can revoke the authorization at any time by giving written notice to TeleNP Health PLLC at contactus@telenphealth.com
2. A photocopy of this authorization shall constitute a valid authorization.
3. If deemed necessary by TeleNP Health PLLC, you authorize this information to be sent via facsimile transmission (fax).
4. By signing this form, you waive the right to hold us legally accountable or liable for the release of your medical records.

Authorized Person/Organization Information

I authorize TeleNP Health PLLC (select all that apply): *

☐ to Obtain Protected Health information from

☐ to Release Protected Health information to

the provider, individual or organization named below:

Name of Individual, Provider and/or Organization: *

identify relationship with patient

☐ self ☐ primary care provider ☐ healthcare provider ☐ family member ☐ Other

Address

Phone Number: * _____

Fax Number: * _____

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***Release of patient health information via FAX machine: I accept the risk of misdirected information via misdialed phone number and misdirected release within the receiving facility/company.**

I understand, INITIAL here * _____

Recipient Email: _____

*** Release of Patient health Information via email: I am authorizing TeleNP Health PLLC to disclose my PHI via email and I accept the risk.**

• I understand that email may not be encrypted and, therefore, may not be considered secure.

• I understand that there is a potential that information can be obtained by unauthorized individuals.

• I acknowledge that TeleNP Health PLLC cannot guarantee security of emails and agree that TeleNP Health PLLC shall not be liable for a breach of confidentiality resulting from an electronic security issue.

I understand, INITIAL here * _____

I authorize the disclosure of patient health information by (select all that apply): *

- ☐ Email
- ☐ Secure Fax
- ☐ Verbal Communication

Purpose

The purpose of this disclosure of information is for review of past medical history, to improve assessment and treatment planning, share information relevant to treatment and/ or coordinate treatment services.

And the following purpose:

- ☐ Treatment/continuing care
- ☐ Billing or Insurance
- ☐ Personal use
- ☐ Legal Proceedings
- ☐ School
- ☐ Other

Health Information/Record Details

I specifically authorize the following parts of my medical record to be disclosed,

if such records exist:

- ☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.
- ☐ Transcribed Hospital Records
- ☐ Diagnostic Imaging Reports
- ☐ Pathology Reports
- ☐ Emergency and Urgent Care Records
- ☐ Laboratory Reports

or I specifically limit this authorization to records regarding the following treatment:

I understand that my medical record includes information on diagnosis/treatment related to psychological or psychiatric condition(s) and may also include the following.

Please select to indicate you give permission to disclose the following sensitive patient information, if present in your record:

- ☐ Communicable diseases including, but not limited to, HIV/AIDS Related Records
- ☐ Genetic Testing Information
- ☐ Drug/Alcohol Diagnosis, Treatment, or Referral Information

This information has been disclosed from records protected by Federal confidentiality rules (42CFR Part II) and NJ State Rules. The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II.

Expiration and Revocation

Unless otherwise revoked, this authorization expires 1 year after date of signature/ authorization

or as otherwise indicated for the following time period and/or event: _____

Authorization Agreement

• I understand that I have the right to revoke this authorization, in writing to the authorized person or organization, and at any time, except where uses or disclosures have already been made based upon my original permission

• I understand that discussions and disclosures already made based upon my original permission cannot be taken back

• I understand I may not be able to revoke this authorization if the purpose was to obtain insurance

• This authorization will automatically expire 12 months from the date signed unless otherwise specified above

• I understand that TeleNP Health PLLC cannot control how the recipient uses or shares the information, and it is possible that information disclosed under the terms of the authorization may be re-disclosed by a recipient and no longer protected by HIPAA privacy standards

• I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment or eligibility for care.

This authorization must be dated and signed by the patient or by a legally authorized person.

By my signature below, I hereby, knowingly and voluntarily, authorize TeleNP Health PLLC to use, obtain, and/ or disclose my health information in the manner described above. I attest that the signature below is my own and I am legally authorized to sign this document:

Patient Signature * _____

Date: * _____

FOR PERSONAL REPRESENTATIVES ONLY

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Check box that indicates your legal authority to sign on patient's behalf:

- ☐ Parent of Minor
- ☐ Power of Attorney
- ☐ Guardian/Conservator
- ☐ Health Care Agent/Proxy
- ☐ Attorney
- ☐ Representative of Estate/ Executor

Parent's / Personal Representative's Signature _____

Date _____