

OFFICE OF ZORICA MERCADANTE, MD

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

As provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to authorize disclosure of your protected health information (PHI). Once received, our office has implemented safeguards to protect your health information (a notice of our Privacy Practices is available upon request or on our website: www.NiMedical.com .)

Patient Name: _____

Home Address: _____

Date of Birth: _____

Home Telephone: () _____

I hereby authorize:

Release this health information to:

Zorica J. Mercadante, MD

New Image Medical Center, LLC

103 Parker Road, Suite B

West Long Branch, NJ 07764

tele: (732) 923-1777

fax: (732) 923-1772

Signature of Individual/Designated Personal Representative

Date

Printed name of Patient Printed name of Personal Representative

If Individual is a minor, please complete the information below:

Signature of Parent

Date

Printed name of Parent or Legal Guardian