Hackensack Sleep & Pulmonary Center

170 Prospect Avenue, Suite 20, Hackensack, NJ 07601
Dr. Fariborz Ashtyani and Dr. Deborah (Hutter) Goss
201-996-0232

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize use or release of the information described below.

Patient Name Date of Birth SS#

Address Telephone Number
(City, State, Zip Code)

This information may be released by:
Hackensack Sleep and Pulmonary Center, LLC; Fariborz Ashtyani, MD; Deborah A. Goss (Hutter), MD and her associates involved in the management and treatment of pulmonary, critical care and sleep medicine.

This information may be released to:

Hackensack University Medical Center
CureMD
Insurance Providers
Physicians involved in your care
and may be used for quality management and research

Treatment dates:

Past, Present, and Future Medical Records

Purpose of Request:

To provide medical information necessary for providing medical treatment and billing of services

The following information is to be released:
Data concerning patients' medical conditions and the treatment received, including personal identifiers, insurance information and financial information.

Sensitive Information:
I understand that the information in my record may indude information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or lnfedion with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke:
I understand that I have the right to revoke (or cancel) this authorization at any time. I understand If I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration:
Unless otherwise revoked, this authorization has no expiration date.

Redisclosure:
I understand that my information may be re-released by the organization that receives It, and the information may no longer be protected by federal confidentiality rules.

Other Rights:
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, since this authorization is needed for reimbursement from payers, refusal to sign this form may result in personal financial responsibility for received care.

I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have any questions about the use or release of my health information, I can contact Dr. Fariborz Ashtyani or Dr. Deborah A. Goss (Hutter) at 201-996-0232.

Signature of Patient or
Legally Authorized Representative Date

If signed by Legally Authorized Representative, relationship to Patient