GARDEN STATE PHYSICIANS P.C.

Dr. Sonia Deora, D.O
Dr. Srinivas Mendu, M.D

Board Certified Physicians in Family Medicine & Internal Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO RELEASE

I, _____ acknowledge that I was provided written copy of the Notice of Privacy Practices for Garden State Physicians P.C. and I authorize Garden State Physicians and staff to release my health information to _____

Relationship to you

address _____

_____ Phone no _____

I give permission for my test results to be faxed to me should I request them. ☐ Yes ☐ No

_____

YOUR SIGNATURE

This authorization shall be in force and effect until you make changes to it in writing. At which time this authorization to use or disclose this protected health information expires.
I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Garden State Physicians, P.C.
10 Jefferson Plaza, Ste 100
Princeton, NJ 08540

I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization was required for treatment provided by participating in a research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive research related treatment or treatment that I have requested for the purpose of disclosure to others.