Montclair Breast Center
Expertise · Experience · Compassion

INDIVIDUAL PATIENT AUTHORIZATION

This form is to confirm your authorization for Montclair Breast Center to disclose and/or release your protected health information for a special purpose. For example:

1. To allow friends or family to have access and discuss your protected medical information with this office.
2. If you are part of a clinical study and/or would like a specific organization to have access, receive and use your protected health information.
3. To allow your physician's office to receive reports and discuss your protected medical information with this office.

Describe what type of information can be discussed or released: Test results, visit information or All Medical Information, are examples of what you can write.

_____

_____

_____

Please name the people or organization you are authorizing to receive your protected health information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Physician: _____

Physician: _____

_____ _____

Signature of Patient or Responsible Party **Date**

You have a right to have a copy of this form after you sign it.