

**Andrew L. Simon, M.D., F.A.C.S., P.A.**

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE  
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize **Andrew L. Simon, M.D., F.A.C.S., P.A.** to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits **Andrew L. Simon, M.D., F.A.C.S., P.A.** to use or disclose to \_\_\_\_\_ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization will expire on \_\_\_\_\_  
{Expiration Date or Defined Event}.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that **Andrew L. Simon M.D., F.A.C.S., P.A.** has acted in reliance upon this authorization. My written revocation must be submitted to ANDREW L. SIMON'S Privacy Officer at 459 JACK MARTIN BLVD SUITE 3 BRICK N.J. 08724.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian Relationship to Patient

\_\_\_\_\_  
Patient's Name Date

\*These Guidelines for Policy Adherence may not be explicitly stated in the Privacy Rule. Some are based on our interpretation of the "minimum necessary" standard and our experience in practice management. If stated in the Privacy Rule, it is so indicated by the notation (Regulation) at the end of the Guidelines, otherwise the notation (Suggestion) follows.