PETER T. HETZLER, M.D., LLC
Plastic and Reconstructive Surgery
200 White Road, Suite 211, Little Silver, NJ 07739
732-219-0447

I authorize the use and/or disclosure of my protected health information as described below.

NAME:_____ DATE: _____

ADDRESS: _____

TELEPHONE _____ SOC SEC #: _____

1. My authorization applies to the information described below. Only this information may be used/or disclosed

____ All information/no restrictions

____ Restrictions as listed _____

2. I authorize the following persons (or class of persons) to make the authorized use and /or disclosure of my protected health information

____ Physician Peter Hetzler, M.D., FACS

____ Physicians staff

3. I authorize the following persons (or class of persons) to receive my protected health information

____ Family (please list names) _____

____ No Fault Carriers (automobile) and adjusters associated with no fault

____ Name of Insurance Carrier _____ associated directly with my treatment

____ Workers compensation including adjusters and case managers associated with my case and any insurance claim review companies associated with workers compensation insurance

4. I authorize the release of my photos to the following

____ To be viewed by other patients in physicians photography portfolio

____ My insurance company

____ I do not authorize the release of my photography

5. I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-diclosed and would no longer be protected

6. I understand that I have a right to revoke this authorization at any time. My revocation must be done in writing. I am aware that my revocation is not retroactive.

7. This authorization expires upon 3 years after my last treatment by Peter T. Hetzler, MD

8. I understand that I do not have to sign this authorization and that my refusal will not affect my abilities to obtain treatment from Peter T. Hetzler, MD

9. My protected health information will be used or disclosed upon request for the following purpose:

    Obtaining authorization for treatment
    Disability (wit proper authorization)
    Scheduling treatment
    Social Security (with proper authorization)
    Billing and collecting payment for medical services
    Referral to other physicians fro Peter T. Hetzler, MD

10. I understand that I have a right to inspect and copy my own protected health information

11. Changes to the above documentation must be submitted in writing to Peter T. Hetzler, M.D., LLC. Changes will be effective immediately upon receipt of certified request.

By signing this form, you are granting consent to Peter T. Hetzler, M.D., LLC to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revisions by calling (732) 219-0447.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Signature Date

_____

Print Name

_____ _____

Name or personal representative Relationship to patient

Revised September 30, 2009