PETER T. HETZLER
MD, FACS

Plastic and Reconstructive Surgery
200 White Road, Suite 211, Little Silver, NJ 07739

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 T Hetzler, M.D., FACS and Physician's Staff

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

____ Family (please list names) _____

____ Dr. Hetzler's associated Billing Service for purposes of processing my claim

____ Insurance Carrier associated directly with my treatment

____ Disability or Workers compensation adjusters and case managers associated with my case

4. 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-disclosed and would no longer be protected

5. 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.

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

7. 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, FACS

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

Obtaining authorization for treatment
Disability (with proper authorization)
Scheduling treatment
Social Security (with proper authorization)

Billing and collecting payment for medical and surgical services
Referral to other physicians from Peter T. Hetzler, MD, FACS
Notifications from Red Bank Call Center via phone/fax/text to Peter. T. Hetzler MD, FACS and/or staff

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

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

By signing this form, you are granting consent to Peter T. Hetzler, M.D., FACS 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 06.2019