



Montclair Breast Center
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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 members of your family—i.e., spouse, partner, parent, siblings, children—to have access and discuss your protected medical information with this office.
2. To allow a family friend to have access and discuss your protected medical information with this office.
3. 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.

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: _____

Signature of Patient or Responsible Party

Date

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