

AvedaMed, LLC
2130 Millburn Ave, Suite A4
Maplewood, NJ 07040
Phone: (973) 761-6111
Fax: (973) 761-6111
Info@AvedaMed.com
AvedaMed.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

(HIPAA-Compliant Authorization Form)

Patient Information

Patient Name: _____**Date of Birth:** _____
Phone Number: _____

Authorizing Disclosure

I, _____, hereby authorize: **AvedaMed,LLC,** and its affiliated physicians, providers, staff, and authorized representatives (collectively referred to as "Healthcare Providers") **Address:** 2130 Millburn Ave, Suite A4, Maplewood, NJ 07040 **Phone:** 973-761-6111 to release the below indicated information/records to the below listed **RECIPIENT OF INFORMATION.**

Recipient of Information (Who Will Receive Records)

Name of Receiving Provider/Facility/Individual:

_____

Address:

_____

Phone/Fax:

_____

Purpose of Disclosure

(Select one or specify)

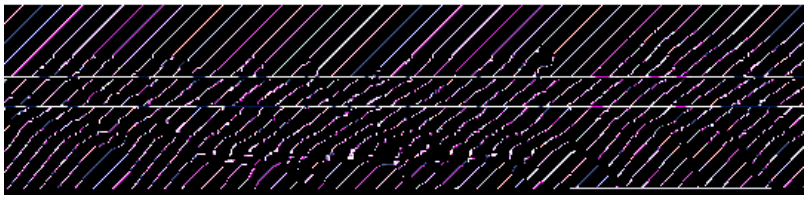
☐ Continuity of Care / Treatment
☐ Patient Request
☐ Legal / Insurance
☐ Other: _____

Information to Be Released

(Select all that apply)

☐ Complete Medical Record
☐ Office Visit Notes
☐ Imaging Reports
☐ Operative Reports
☐ Billing Records
☐ Lab Results
☐ Other: _____

Patient Initial: _____ Date: _____



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Date(s) of Service: _____

Revocation
I understand that I may revoke this authorization at any time by submitting a written request to the Privacy Officer at: **2130 Millburn Ave, Suite A4, Maplewood, NJ 07040.** Revocation will not apply to information already disclosed prior to receipt of the request.

Authorization Duration
This authorization will remain valid for **three (3) years from my last date of service**, unless revoked earlier in writing.

Acknowledgment & Understanding

- I understand that signing this authorization is **voluntary** and not required to receive treatment.
- I understand that once my PHI is disclosed to parties not subject to HIPAA, it may no longer be protected.
- I acknowledge receipt of the **Notice of Privacy Practices**, which may be updated at any time.
- I understand I may request restrictions on the use of my PHI, though the Provider is not required to agree.

Consent for Use and Disclosure
By signing below, I authorize the use and disclosure of my Protected Health Information as described above.

Patient Name: _____
Patient Signature: _____
Date: _____

Patient Initial: _____ Date: _____