AVEDAMED®
Primary Care | Cardiology | Rheumatology

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)/HIPAA RELEASE

I, _____ , authorize and agree that **the Healthcare Providers, Entities, and Individuals listed below are hereby granted permission to request and receive disclosures of any and all of my medical records or protected health information (PHI):**

- **AvedaMed, LLC**, its affiliated providers, and staff (collectively referred to as " Healthcare Providers")
    - "Healthcare Providers" may be defined as any other parties/entities directly involved in/or providing services and/or equipment for my care. This may include: (1) other healthcare providers involved in my ongoing care under this agreement, vendors of medical equipment, and/or any other entity, carrier, employer, or representative financing/providing medical insurance coverage or care to me in collaboration with my Healthcare Providers.
- **The below-listed individuals/Designated representatives/friends/or family (Must include their First and Last Name):**

  _____
  _____
  _____

Revocation: I may revoke this authorization at any time by submitting a written request to my "Healthcare Providers" Privacy Officer at 2130 Millburn Ave, Ste A-4, Maplewood, NJ 07040. Revocation will not affect actions taken before the request is received.

Notice of Privacy Practices: I acknowledge receipt of my "Healthcare Providers" Notice of Privacy Practices, which may change at any time. I may request the most up-to-date version of Privacy Practices by emailing my "Healthcare Providers" at Info@AvedaMed.com or by calling 973-761-6111

Authorization Duration: This authorization remains valid for three years from my last date of service with Providers. I understand that if my PHI is shared with entities not bound by HIPAA, it may no longer be protected by federal privacy laws.

Consent for Use: I understand that signing this authorization is not required to receive treatment and that I may request restrictions on the use of my PHI for treatment, payment, or operations. While Providers are not required to agree to these restrictions, any agreed limits are binding.

By signing below, I consent to the use and disclosure of my PHI for the purposes described above.

Signature: _____ **Date:** _____