NEW JERSEY
NECK & BACK
INSTITUTE, P.C.

Sandro LaRocca, M.D.
3131 Princeton Pike
Building 6, Suite 106
Lawrenceville, NJ 08648
phone: 609-896-0020
fax: 609-896-0041
web: www.NJNBI.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

I, _____ , hereby authorize

(Please check all that apply)

□ Capital Health Systems
□ University Medical Center at Princeton Plainsboro
□ Robert Wood Johnson Hamilton
□ Princeton Radiology (Quakerbridge Radiology, Hillsboro Radiology, Windsor Radiology)
□ Radiology Affiliates
□ University Radiology
□ Other _____

and its affiliates, its/their employees and agents, to release to **New Jersey Neck & Back Institute, P.C.** my personal health information.

This authorization is in effect for 12 months unless otherwise revoked by me. I understand that I have a right to revoke this authorization by providing written notice to

New Jersey Neck & Back Institute, P.C.
3131 Princeton Pike
Building 6, Suite 106
Lawrenceville, NJ 08648.

However, this authorization may not be revoked if New Jersey Neck & Back Institute, P.C., it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Patient Name _____

Patient Signature _____

Date _____