



NEW JERSEY
NECK & BACK
INSTITUTE, P.C.

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3131 Princeton Pike
Building 6, Suite 106
Lawrenceville, NJ 08648

phone: 609-896-0020
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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 _____