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HACKENSACK, NJ 07601

PATIENT PRIVACY PROTECTION

TO WHOM IT MAY CONCERN:

I specifically direct the above not to copy or release any medical or health related information, records, history, or data to any person, including local, state, and/or federal government agencies without my express and specific written permission with each such request.

If I am legally declared incompetent or if I am physically unable to do so, consent may be given, in writing, by my heirs or assigns to release and access above.

NAME:_____
(Print Patient Name)

ADDRESS:_____
(Print Patient Address)

CITY/STATE/ZIP:_____
(Print Patient Address)

SIGNATURE:_____
(Patient Signature)

WITNESS:_____
(Witness Signature)

DATE:_____
(Date Patient and Witness Signed)