Joseph Cipriano, M.D. FACOG
Rebecca Cipriano, M.D. FACOG
Susan Pacana, M.D. FACOG
Neeti Misra, M.D. FACOG
Elizabeth Scheff, M.D. FACOG
Borislava Burt- Libo DO
Julie Leizer, M.D.

www.healthywomanusa.com

Stephanie Serrentino
Executive Director

Colleen Behrens
Office Manager

Grace Kasnowski
Prenatal Coordinator

Freehold
312 Professional View Drive
Building 300, Second Floor
Freehold, NJ 07728
Ph: (732) 431 – 1616
Fax: (732) 866 - 7962

Colts Neck
340 Highway 34
Suite D-2
Colts Neck, NJ 07722
Ph: (732) 431 – 1616
Fax: (732) 866 - 7962

Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at Healthy Woman to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered *:

______________________________ ______________________________
Name of designated person Relationship to patient

______________________________ ______________________________
Name of designated person Relationship to patient

☐ **I DO NOT wish to designate any person(s) ***

Please note for children under 18 years of age, information will be released to the parent or legal guardian.

I authorize the release of my Protected Health Information to the following physician(s) or facility(s) upon request of the physician(s) or facility(s) for the purpose of my treatment:

______________________________ ______________________________
Name of designated Physician or Facility Type of Physician or Facility

______________________________ ______________________________
Name of designated Physician or Facility Type of Physician or Facility

☐ **I DO NOT wish to designate any physician(s) or facility(s)**

I understand that in order to ensure continuation of care, the staff and/or physicians at Healthy Woman may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

☐ **I DO wish to have messages left** ☐ **I DO NOT wish to have messages left**
☐ **I DO NOT wish to have email sent**

I also understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/ information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

______________________________ X______________________________
Patient Printed Name Patient Signature

____/____/______
Date

Privacy Practices Acknowledgement

I have reviewed / received the Notice of Privacy Practices for Healthy Woman

______________________________ X______________________________
Patient Printed Name Patient Signature

____/____/______
Date