DR. DON RESPLER
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HACKENSACK, NJ 07601
(201) 996-9200

ENT Institute of NJ

# HIPAA COMPLIANCE FORM

This form protects the privacy of your medical records and directs our office to release your medical information *only* to those people and entities that you choose below. Please be sure to include every doctor, school and person with whom you would like us to share your medical information

Name: Date of Birth:

Address: City, State Zip

Phone 1 Phone 2 Email

Other than my PCP, insurance and ENT referral for coordination of ENT treatment, I authorize this office to share my medical information with the following individual(s), department(s), doctor(s), relative(s), school(s) and/or office(s)

| Name or Entity | relationship | contact info |
|---|---|---|
| | | |
| Name or Entity | relationship | contact info |
| | | |
| Name or Entity | relationship | contact info |
| | | |
| Name or Entity | relationship | contact info |
| | | |

**I understand that I have a right to revoke or replace this HIPAA release form at any time. I understand that any replacement HIPAA form must include my name, address, contact information and signature and will not affect any disclosure that has been already made in reliance of today's HIPAA authorization This HIPAA form will remain in force until revoked or replaced. I confirm that this HIPAA directive reflects my wishes and has been completed and signed voluntarily.**

**Patient or Parent/Guardian/Representative signature** **DATE: MM/DD/YYYY**

Please print name of signer and relationship (Patient, mother, father, Legal guardian, etc)

**For any questions or objections, please contact our HIPAA team at 201-996-9200 or via email at angelsofENT@gmail.com**