RELEASE OF PERSONAL HEALTH INFORMATION

ROBERT S. PATITUCCI, M.D.
70 CORNWELL DRIVE
BRIDGETON, NJ 08302
856-455-6770
FAX 856-455-6030

I,_____, give my permission to:
PATIENT'S NAME

_____.
NAME OF PERSON TO RECEIVE *PHI*

PLEASE CHECK ALL THAT APPLY:

_____ MAKE & RECEIVE PHONE CALLS REGARDING MY *PHI* IN MY ABSENCE

_____ PICK UP FORMS, PRESCRIPTIONS, REFERRALS AND/OR SAMPLES FOR ME IN MY ABSENCE

_____ RECEIVE BILLING INFORMATION

PLEASE INCLUDE ANY ADDITIONAL RELEASE OF PHI THAT IS NOT INCLUDED ABOVE

_____

_____

_____

PATIENT'S SIGNATURE:_____

TODAY'S DATE:_____