Lingraphica®

Authorization to Release Protected Health Information

Lingraphica follows all Health Insurance Portability and Accountability Act (HIPAA) guidelines with respect to protected health information, and we ask all patients to sign this release.

I hereby authorize the release/use/disclosure of my health information as it relates to treatment, prognosis, and diagnosis. Records that may be released include: all medical records pertaining to my medical history.

I understand that signing this authorization is voluntary. I understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise required by law (e.g., Medicare Law). I understand that a photocopy of this authorization that is delivered in person, by mail, e-mail, or fax is as valid as the original.

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ Other Phone: _____ Email: _____

Please release authorized health information to:

Lingraphicare America, Inc.
Fax: 1-609-275-1311
103 Carnegie Center
Suite 104
Princeton, NJ 08540

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to an employee of Lingraphicare America, Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not revoke this authorization, it will automatically expire one year from its signature date.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this authorization does not limit the above-named healthcare provider, employees, or agents' ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

Authorized Signature: _____ Date: _____

Printed Name: _____ Relation to Patient (if other than patient): _____

Reason Patient unable to sign: _____