

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
                    Street                    City                    State                    Zip

MARITAL STATUS: S M W D SOCIAL SECURITY#: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

**EMERGENCY CONTACT & NUMBER:** \_\_\_\_\_

PATIENT EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

**PRIMARY INSURANCE COMPANY:** \_\_\_\_\_

I.D./POLICY NUMBER: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ (If different than patient)

SOCIAL SECURITY #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:** \_\_\_\_\_

I.D./POLICY NUMBER: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ (If different than patient)

SOCIAL SECURITY#: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PHARMACY PHONE: ( ) \_\_\_\_\_

PRIMARY CARE PHYSICIAN NAME: \_\_\_\_\_

\*\*\*\*\*

\*\*\*PAYMENT IS EXPECTED AT THE TIME OF THE VISIT\*\*\*

ASSIGN AND RELEASE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID TO DR. PITTER. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



**MICHAEL C. PITTER, M.D., F.A.C.O.G.**

*Obstetrics, Gynecology, Infertility & Robotic Surgery  
Diplomate American Board of Obstetrics & Gynecology*

**DR PITTER, M.D.**

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Newark, NJ 07112  
Telephone: (973) 926-4600  
Fax: (973) 926-4601

Essex Ob/Gyn. P.C.  
385 Prospect Avenue  
3rd Floor  
Hackensack, NJ 07601  
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Fax: (201) 488-7273

**PLEASE PROVIDE A LIST OF NAMES YOU AUTHORIZE  
DR. PITTER AND STAFF TO RELEASE AND/OR DISCUSS  
YOUR MEDICAL INFORMATION.**

1. \_\_\_\_\_ Relationship \_\_\_\_\_
2. \_\_\_\_\_ Relationship \_\_\_\_\_
3. \_\_\_\_\_ Relationship \_\_\_\_\_
4. \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Individual's Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SPECIFY INFORMATION TO BE DISCLOSED:**

- |   |   |
|---|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Reports    |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Billing Records      |
| <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> Entire Chart         |
| <input type="checkbox"/> Operative Report   | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Other _____        |   |

**MY HIGHLY CONFIDENTIAL INFORMATION:**

By signing my name next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- HIV/AIDS Related Information \_\_\_\_\_  
(including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Genetic Information \_\_\_\_\_
- Venereal Disease Information \_\_\_\_\_
- Tuberculosis Information \_\_\_\_\_
- Drug and Alcohol Information \_\_\_\_\_

**RECIPIENT:** Name of person or class or persons to whom Dr. Pitter office may disclose my health information: \_\_\_\_\_  
Or address of where my health information should be delivered: \_\_\_\_\_

**TERM:** This Authorization will remain in effect:  
From the date of this Authorization until the \_\_ day of \_\_, 200\_\_.  
Until the following event occurs: \_\_\_\_\_  
Other: \_\_\_\_\_

This authorization will expire in 90 days *unless* an earlier date is indicated by you.

I understand that once Dr. Pitter's office discloses my health information to the recipient, Dr. Pitter's office cannot guarantee that the recipient will not redisclose my health information to a third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Dr. Pitter's office.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice or revocation will be effective immediately upon Dr. Pitter's office receipt of my written notice.

I may contact Dr. Pitter's Privacy Office By mail At 201 Lyons Avenue, L-2 Newark, NJ 07112 or by telephone at (973) 926-4600.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Dr. Pitter's Office to use or disclose my health information in the manner described above.

\_\_\_\_\_  
Signature Of Patient

\_\_\_\_\_  
Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following Signatures:

\_\_\_\_\_  
Signature Of Personal Representative

\_\_\_\_\_  
Description of Authority

\_\_\_\_\_  
Date