THOMAS J. MARZILI, MD, LLC
733 Route 70 East
Building 2, Suite 201
Marlton, NJ 08053
(609) 451-2020

HIPAA-ACKNOWLEDGMENT OF RECEIPT
Notice of Privacy Practices

Printed Patient Name: ____
Patient Birth Date: ____/____/________

We at the office of Dr. Thomas Marzili are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

____ ____/____/________
Signature of patient or patient's representative/parent Date

____
Printed name of patient or patient's representative/parent

____
Relationship to patient

PERMISSION TO OBTAIN MEDICAL RECORDS

By signing below, I grant permission to the office of Thomas J. Marzili, MD, to obtain medical records including previous doctor's records, hospital records, specialists' results, labs, x-ray, prescriptions records and other medical information that may contribute to my healthcare.

____ ____/____/________
Signature of patient or patient's representative/parent Date

____
Printed name of patient or patient's representative/parent

____
Relationship to patient

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Phone (609) 451-2020
Fax (609) 451-2021

If records need to be obtained, please provide name, address and fax number of physician / facility
Thanks!