Princeton Gastroenterology Associates
731 Alexander Road Suite 100
Princeton, NJ 08540
Telephone (609) 924-1422
Fax (609) 924-7473

Authorization for the Release of Medical Information

IDENTIFYING INFORMATION:

Patient name: _____ Date of birth: _____

Telephone number: _____

REQUESTOR INFORMATION: Information is to be released to the following individual or party

Name: _____

Address: _____
Street/P.O. Box City State Zip Code

Telephone number: _____ Fax number: _____

The purpose or need for disclosure: _____

Date range of information to be released: from _____ to _____
(month / year) (month / year)

AUTHORIZATION: Permission is hereby granted to Princeton Gastroenterology Associates to release medical information to the individual/organization as identified above.

(*Note: submission of this form authorizes the release of the information specified within **one year** from the date of signature.)*

Patient/ Authorized Signature _____

Print name _____ Date _____