PRINCETON GASTROENTEROLOGY ASSOC, PA

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPPA, requires that our office has your consent prior to our healthcare professional discussing your personal health with your family members or significant others.

Can our physicians discuss your healthcare with any of your family members?

Please circle those that apply.

Spouse Significant Other Mother Father Sister Brother Child

Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

What Kind of health information do you authorize Princeton Gastroenterology to disclose to the designated person(s)?

___ All – at my physician's discretion ___ Tests ordered ___ Test Results

___ Dates of Treatment ___ Diagnosis ___ Treatment Options

___ Treatment Plan ___ Medical History ___ Other_____

This authorization will be in effect until until such time you request its revision. You have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy officer at the office above.

You do not have to complete this authorization in order to receive treatment from Princeton Gastroenterology.

Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

_____ _____

Signature Print Name