MIDDLESEX/MONMOUTH GASTROENTEROLOGY

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Drs. Blank, Nadler, Geller, Brown, Gupta, Waller and staff to contact me with test results and other protected health information in the following manner:

(Please check all appropriate selections.)

Home telephone # _____________________________answering machine:

☐ Do not call this number
☐ OK to leave message **to call back only**
☐ OK to leave message **with results and detailed information**

Cell phone # __________________________________ voice mail:

☐ Do not call this number
☐ OK to leave message **to call back only**
☐ OK to leave message **with results and detailed information**

Work telephone # _____________________________ voice mail:

☐ Do not call this number
☐ OK to leave message **to call back only**
☐ OK to leave message **with results and detailed information**

Other persons authorized to receive my health information:

Name_____________________________Relationship__________________Phone_______________

Name_____________________________ Relationship_________________ Phone_______________

Restrictions to above if any: ____

PLEASE COMPLETE THE FOLLOWING:

The above authorization will apply to the time period as follows:

From today ______/_______/_______ **until:** ☐ **I cancel this authorization.**

OR ☐ until this date _______/_______/_______

Patient name (PRINT) __________________________________ Date of Birth_____/_____/_____

Signature____ Date _______/_______/_______