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Flemington, NJ 08822

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Somerville Location
135 West End Avenue
Somerville, NJ 08876

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize _____
 To disclose information from the records of: _____

Patient Name Date of Birth

The information is to be:

Released From: Hunterdon Gastroenterology Associates	Released To: Hunterdon Gastroenterology Associates
To: _____	From: _____
_____	_____
_____	_____

- Purpose for request: for personal use only transferring care to another local practice due to: date of appt. : _____
 (not transferring from practice) _____
 relocation out of area insurance change related (please indicate carrier) _____
 Other: _____

The following information is to be released: (please check one)

_____ Entire Medical Record. Records specifically protected under State and Federal confidentiality statutes. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse, AIDS/HIV related, genetic, venereal disease or tuberculosis information, which are protected under State and Federal law and prohibits any further disclosure without written consent of the persons to whom it pertains or otherwise provided by law.

_____ Only specific portions of the medical record. Itemize portions of the record and time period of records to be released and indicate specific records that may not be released.

Having read the above information, I release Hunterdon Gastroenterology Associates, its employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of information set forth above relating to my Protected Health Information. A copying fee may be charged.

I understand that this authorization will remain in effect for 180 days or until I provide a written notice of revocation to Hunterdon Gastroenterology Associates Medical Records Department. The revocation will be effective immediately upon Hunterdon Gastroenterology Associates receipt of the written notice. I understand that revocation may not be made if the action has already been acted upon based on prior authorization.

Date of Signature

Patients Signature

Witness

Signature of Responsible Party

If the patient is unable to sign, complete the following:

- Patient is a minor _____ years of age
 Patient is unable to sign because _____