Hunterdon Gastroenterology Associates
Medical Experts in the Treatment of Digestive Diseases

Hunterdon Doctors Office Building
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Flemington, NJ 08822

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F: 908-788-5090

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

Purpose for request: (Please Circle)

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

How would you like to receive your records? (Please Circle)

Paper form
Electronic Form (USB/CD)
Patient Portal

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

_____Entire Medical Record. Records specifically protected under State and Federal confidentiality statues. 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 _____

4/2025 mk