WRITTEN AUTHORIZATION REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I have received a copy of the Privacy Notice. _____

I authorize the use/disclosure of health information about me as described below.

1. Person(s) authorized to use/disclose the information.
   Hunterdon Surgical Associates P.A.

2. Person(s) you wish to receive the information. Please list names and relationship. (Examples: spouse, friend, sibling, parent, child other Physicians.)

   ____

3. Describe any restrictions on what information or details that may be disclosed.

   ____

4. Please list the numbers & places where we can contact you and leave messages for you.

Call	Leave message Y or N
Home: ______________	______
Work: ______________	______
Cell: ______________	______

   Emergency contact number ______________________

5. I understand that I may revoke this authorization in writing at any time. This authorization is valid until revoked or changed by the patient or legal guardian.

__________________________ __________________
Signature of Patient or Representative Date

____
Print Patient's Name

__________________________ ________________
Name or Parent/Legal Guardian if applicable Relationship

Your preferred pharmacy is ______________________ in what town ______________________ phone number ______________________