PRINCETON OTOLARYNGOLOGY ASSOCIATES
7 SCHALKS CROSSING RD, SUITE 324
PLAINSBORO, NJ 08536
PHONE 609-897-0203
FAX 609-897-0213

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPPA, requires that our office have 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 kinds of health information do you authorize Princeton Otolaryngology Associates, P.A., 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 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 office at the address above.

You do not have to complete this authorization in order to receive treatment from Princeton Otolaryngology Associates, P.A.

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.

_____ _____
Print Name Date of Birth

_____ _____
Signature Date