Matthew A. Berger, MD, PC
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AUTHORIZATION FOR DISCUSSION OF PROTECTED HEALTH INFORMATION (HIPAA AUTHORIZATION)

I, (please print name) _____, hereby give permission for Matthew A. Berger, MD, PC or his designee to contact and discuss information concerning my history, current care and prognosis. This is to include but is not limited to: medical history and physical, progress notes, psychological and social history, drug and alcohol history, case history, laboratory results and mental status examination.

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The purpose of the information is to provide overall continuity of care between myself and family and friends who are involved in my total care and treatment.

I hereby give permission to the following people to speak with Matthew A. Berger, MD, PC or his designee and receive the above mentioned protected health information.

Name _____ **Relationship to Patient** _____ **Phone** _____

Name _____ **Relationship to Patient** _____ **Phone** _____

Name _____ **Relationship to Patient** _____ **Phone** _____

I understand I am not obligated to disclose information if I do not wish to. I may revoke the above authorization at any time by written request.

I certify I understand this form and have had the opportunity to ask questions concerning this form.

Patient Signature* _____ **Date** _____

Legal Guardian Name** _____

Legal Guardian Signature** _____ **Date** _____

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*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

If patient is **13 or under, a legal guardian must sign all paperwork.

If you have any questions, please ask our staff.