Mid State Gastroenterology, LLC

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Freehold, NJ 07728**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hearby authorize Dr. Ludwig and staff to contact me with test results and other protected health information in the following manner:

(**Please check appropriate selections.)**

Home telephone #___________________________ answering machine:

- ☐ Do not call this number
- ☐ OK to leave message **to call back only**
- ☐ OK to leave message **with results and detailed information**

Cell phone# _________________________________voicemail:

- ☐ Do not call this number
- ☐ OK to leave message **to call back only**
- ☐ OK to leave message **with results and detailed information** **Work telephone#**

____________________________voicemail:

- ☐ Do not call this number
- ☐ OK to leave message **to call back only**
- ☐ OK to leave message **with results and detailed information**

Other persons authorized to receive my health information:

Name___________________________ Relationship___________ Phone______________

Name ___________________________ Relationship___________ Phone______________

Restrictions to above if any: ____

PLEASE COMPLETE THE FOLLOWING!

The above authorization will apply to the time period as follows:

From today ___/____/____ until: ( ) **I cancel this authorization**

OR ( ) until this date ____/___/___

Patient name (print)_____________________________ Date of Birth ___/___/_____

Signature ______________________________________ Date_____________________