

Mid State Gastroenterology, LLC

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby 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 _____