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_____