Plainsboro Pediatrics
666 Plainsboro Road, #516
Plainsboro, NJ 08536
609-799-0068

HIPAA Authorization Form for Family Members/Friends

I, _____, grant permission to Plainsboro Pediatrics to disclose and release my protected health information (PHI) to the following persons:

Name(s) Relationship

_____

_____

_____

_____

Health Information to be disclosed (check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information (check appropriate)
  - ◯ Mental health records
  - ◯ Communicable diseases (including HIV and AIDS)
  - ◯ Alcohol/drug abuse treatment
  - ☐ Other (please specify): _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

Term: I understand that this Authorization will remain in effect (check one)

- ☐ From the date of this Authorization until the following date:_____
- ☐ Until the following event occurs: _____
- ☐ Until this Authorization is revoked in writing_____

_____

Name of the individual giving this Authorization Date of birth

_____

Signature of the individual giving this Authorization Date