Princeton Family Care Associates, LLC
WELLNESS IS A STATE OF MIND

Authorization to Use/Disclose Health Care Information

FULL Patient Name: _____ Date of Birth: _____

Address: _____ City, State: _____

Zip Code: _____ Phone Numbers: _____

I request and authorize Princeton Family Care Associates, LLC to share my health care information as described below with:

Name: _____ Telephone Number: _____

Address: _____ City, State: _____

Zip Code: _____ Relationship: _____

Special Instructions: _____

_____

Purpose of Disclosure:

- ☐ Insurance request
- ☐ Transfer of medical records to new treating physician
- ☐ Coordination of care with other clinicians
- ☐ Fax and call-in prescriptions of Suboxone to pharmacy
- ☐ Other: _____

Patient/Legal Guardian Name: _____ Signature for Release: _____

Witness Name: _____ Witness Signature: _____

Today's Date: _____

Authorization expires TWO YEARS from date of signature or upon written patient notification to our office.

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