ANNE SWEDLUND MD
932 State Road 2nd Floor
Princeton, NJ 08540

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

The health insurance Accountability and Portability Act of 1996, HIPPA, requires that our Office have your consent prior to our healthcare professional discussing your personal health with your family members or significant others.

	Yes	No
Can we leave a voice message for you: Home # _____	___	___
Cell # _____	___	___
Work # _____	___	___

Can we release information to family member. If so, to whom _____
Telephone: _____ Relationship: _____.

This authorization will be in effect until such time you request its revision. You have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization.

You do not have to complete this authorization in order to receive treatment from Dr Anne Swedlund.

Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

_____ Date: _____
Signature