## HILLSBOROUGH MEDICAL ASSOCIATES

## HARPREET K. BAGGA, MD

## **349 U S HIGHWAY 206**

PHONE: (908) 359-4150 FAX: (908) 359-9548

## **AUTHORIZATION TO USE AND DISCLOSURE HEALTH INFORMATION**

Patient's Name_						
Address:						
Home Telephon	e:	Date of Birth:				
INFORMATION	TO BE RELEASED: TO	FROM				
Fax Number:			-TELEPHON	IE NUMBER:_		
DATES OF TREA	TMENT:					
TYPE OF INFOR	MATIOM TO BE DISCLO	OSED: (Circle t	he appropr	iate)		
Office notes	Demographics Imi	munizations	Discharge	Summary		
Consultations	Operative Reports	Lab Reports	Radiolo	gy Reports	Entire	
Purpose of Disc	losure: Medical Care	Insurance Pe	ersonal Le	gal Matter (	Other	
transmitted dise (HIV), it may als	at the informatiom in rease, acquirwed immu o include informatiom cohol and drug abuse	nodeficiency s about behavio	nydrome (A	IDS), or huma	an immunode	eficiency virus
TERM: This Aut	horization will remain	in effect:				
From the date o	f this Authorization ur	ntil the	day of _	•3	20	
Signature of Pa	tient	Date		Signature o	of Witness or	Employee
Signature of au	thorized legal Guardia	n, Health Care	Agent, or o	other authori	zed Persona	l Representative
Relationship		Date		Witn	ness	