Princeton Allergy & Asthma Associates
HIPAA Disclosure Information of Protected Health Information

Patient Name: ____ **Date of Birth:** ____________________

This authorization is given by: _____ **The Patient** ______**Parent/Guardian** ____________________________
Print Name

The physicians/practice may disclose to:

____**Any medical provider/facility** (Sending medical records will still require a written request with a signature)

____**Spouse**_____________________________ ___**Child(ren)**__________________________________
Print Name Print Name

____**Parent**______________________________ __________________________________
Print Name Print Name

____**Other**_______________________________ ____
Print Name Relationship

Princeton Allergy and Asthma uses text messaging to communicate to patients regarding lab/test results, prescription refills, appointments, etc… If you object to receiving texts on your personal mobile device, please notify the receptionist.

This authorization in effect until revoked in writing.

____ Date____________________________
Signature of Patient or Parent/Guardian 2/6/20