DESIGNATION OF DISCLOSURE

Name: (Please print) _____

Designation of Certain Relative, Close Friends and Other Caregivers:
I agree that Endocrinology Associates of Central New Jersey may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, Endocrinology Associates of Central New Jersey will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner(check all that apply):

Telephone, Written and Fax Communication

Home or Cell Telephone Number: ___ (___) _____

___ OK to leave message with detailed information
___ Leave message with call back numbers only

Written Communication:
___ OK to mail to my home address
___ OK to mail to my work/office address

Work Telephone Number: ___ (___) _____
___ OK to leave message with detailed information
___ Leave message with call back numbers only

Fax Communication:
___ OK to fax to this number: ___ (___) _____

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Endocrinology Associates of Central New Jersey making the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time **in writing.**

Name: _____Date of Birth (required): _____
Name: _____Date of Birth (required): _____
Name: _____Date of Birth (required): _____
Name: _____Date of Birth (required): _____
Name: _____Date of Birth (required): _____

The following person(s) are **not authorized** to receive my Patient Health Information:
Name: _____ Name: _____
Name: _____ Name: _____

Signature: _____ Date: _____
Patient/Parent/Guardian