Melissa Selke, M.D., P.C.

Family Medicine

Princeton Medicine

HIPAA PATIENT PRIVACY AND DESIGNATION OF RELATIVES, FRIENDS, AND/OR OTHER CAREGIVERS

RELEASE FORM

Date: _____

I agree that Melissa Selke, M.D., P.C., Princeton Medicine, may disclose certain portions of my health information to a relative, friend, and/or other caregiver because such person is involved with my health care or payment relating to my health care. In that instance, Melissa Selke, M.D., P.C. 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 designate the following persons listed below as persons involved with my health care and/or payment relating to my health care and hereby give permission to Melissa Selke, M.D.,P.C., Princeton Medicine, to discuss and disclose any medical information relating to the limited disclosures described above.
I understand that I am not required to list anyone.

___ **I wish to make no designation at this time.**

Print Name/Relationship: _____ **DOB or Password*:** _____

Print Name/Relationship: _____ **DOB or Password*:** _____

Print Name/Relationship: _____ **DOB or Password*:** _____

**Please list the 4 digit (month and day) date of birth (DOB) of the person(s) listed or choose a password. Please note, the person(s) listed will have to give his/her DOB or password given in order to receive any information.*

Signature of Patient/Parent Guardian: _____

Can we leave a message on home phone answering machine? Yes___ No ___
Can we leave a message on your cell phone:? Yes___No___
Can we leave a message on work phone answering machine? Yes___No___

Can we email information to you? Yes___ No ___ Email address: _____

By signing this form, I acknowledge and understand that I can revoke this permission at any time by submitting a signed statement, and that permission will remain in effect unless we receive a revocation in writing.

Patient Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____