Penn Medicine
Princeton Medicine Physicians

Plainsboro Family Physicians

666 Plainsboro Road, Suite 1316
Plainsboro, NJ 08536

Date: _____

This is to notify Plainsboro Family Physicians that I am restricting the release of my Protected Health Information (PHI). No information may be released without my express written consent as indicated below.

I hereby give permission to Plainsboro Family Physicians to discuss any medical matters with the following person(s):

NAME	RELATIONSHIP	PHONE #
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NAME	RELATIONSHIP	PHONE #

Can we leave a message on home phone answering machine? ☐ Yes ☐ No

Can we leave a message on cellular phone voice mail? ☐ Yes ☐ No

Can we leave a message on work phone answering machine? ☐ Yes ☐ No

I am consenting to allow Plainsboro Family Physicians to place referrals and other PHI in a tamper evident envelope and place it in an unlocked box outside our office door to facilitate pick up by myself or my representative when the office is closed.

PLEASE **INITIAL** ONE YES (initial) _____ NO (initial) _____

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 until I submit a notice of revocation in writing.

Patient Name: _____ Date of Birth: _____

Signature of Insured/Guardian: _____

Office Staff Witness: _____