This form is for you, the patient to give authorization for this practice, **HACKENSACK GASTROENTEROLOGY ASSOCIATES P.A.** to discuss your medical information with a party other than yourself (i.e. spouse, children, parents, friends, etc.). This authorization is optional and can be revised at any time with your signed authorization.

I _____, hereby give my permission to

Hackensack Gastroenterology Associates to discuss any information pertaining to my medical condition and treatment with:

NAME & PHONE NUMBER	RELATIONSHIP TO PT
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT SIGNATURE	DATE
_____	_____