Authorization for Dr. _____

To use or disclose my health care information

Patient name: _____ Date of Birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

__ All health care information in my medical records.

__ Health care information in my medical record relating to the following treatment/condition _____

__ Health care information in my medical records for the date(s): _____

__ Other (e.g. X-rays, bills etc. Please specify date(s) _____

You may use/disclose health care information regarding testing, diagnosis, and treatment for:

__ HIV(AIDS virus) __ Psychiatric disorders/mental health

__ Sexually transmitted diseases __ Drug and/or alcohol use

I authorize the disclosure of my information **Reason(s) for Disclosure**

TO: _____ __ At my request __ Other

_____ __ Transfer of Care

_____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to:
-take part in a research study or,
-to receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Dr. Sheldon Cowen based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed the person or organization receiving it, may re-disclose it. Privacy laws may no longer protect it.

X_____ Date: _____
Patient or legally authorized individual signature

X_____ _____
Printed name if signed on behalf of the patient relationship

A $25 fee will apply for records copied two (2) or more time within a twelve month period.