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AUTHORIZATION TO USE OR RELEASE PERSONAL HEALTH INFORMATION

Patient Name _____

1. I hereby authorize _____ to release the health care information described below to:

   Name _____

   Entity _____

   Address _____

2. This request and authorization applies to only the following health information:

3. List each purpose or reason for the use or release of the protected health information:

4. This authorization shall remain in full force and effect until _____.
5. I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to Amy J. Silverman, M.D.
6. I understand that Dr. Silverman may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.
7. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
8. I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.
9. I understand that I have the right to refuse to sign this authorization.

_____
Signature of Patient or Patient's Personal Representative

_____ _____
Name of Patient or Patient's Personal Representative Date