Form #____

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
(Note: This form cannot be used to authorize a release of HIV-related information.)

Patient Name: _____
Last First Middle

Home Address: _____
_____

Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: _____
_____
_____
_____
_____.

RECIPIENT: Name of person or class of persons to whom the Practice may disclose my health information: _____.
Address of recipient or where my health information should be delivered:_____
_____.

TERM: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills the request.

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s) ("At the request of the patient" is sufficient if the patient is initiating this Authorization): _____
_____
_____.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of

creating PHI for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Practice's Office Manager at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

The address of the Practice's Office Manager is 110 East 40th Street, Suite 707, New York, NY 10016, and I may contact the Office Manager by telephone at 212 986 2500.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Signature of Patient	Date

If the patient is a minor or is otherwise unable to sign this Authorization, please complete the information below:

Signature of authorized Personal Representative	Description of Authority	Date