## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of the named individual's health information as described below:

Patient Name:

Date of Birth:

SS Number:

Address:

Phone:

The following individual / organization is allowed to make the disclosure:

The information may be disclosed to and used by the following individual / organization: DR. DOUGLAS A. WALDMAN **[see above]**

Treatment dates: **ALL**
Purpose of request: **CONTINUED CARE**
The following information is to be disclosed: **COMPLETE MEDICAL RECORD**
Other information:

SENSITIVE INFORMATION : I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome [AIDS], or infection with the human immunodeficiency virus [HIV]. It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

REDISCLOSURE : I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE : I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS : [a] I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. [b] I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION : Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

N/A

If I do not specify an expiration date, event, or condition, this authorization will expire six [6] months from the date of my signature on this authorization.

_____
Signature of patient or legal representative

Date / Time

_____
Relationship to patient

_____
Witness