Form R

David S. Weiss, M.D.

530 First Avenue – Suite 5D · New York, NY 10016

[212] 263-7743 · Fax [212] 263-8810

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

PHYSICIAN/HOSPITAL: _____

_____

_____

_____

Dear Sir/Madam:

The following patient has been or will be seen in consultation:

NAME: _____

BIRTHDATE: _____ / _____ / _____

Approximate dates of service: _____

We would appreciate it if you would kindly send the following information (**INFORMATION TO BE DISCLOSED**):

_____

_____

_____

PLEASE RETURN INFORMATION TO (**RECIPIENT**): David S. Weiss, M.D.
530 First Avenue – Suite 5D
New York, NY 10016

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

By my signature below, I hereby authorize you to disclose to Dr. David Weiss my health information for the term of this Authorization for the following specific purpose: <u>At the request of the patient.</u>

I understand that once you disclose my health information to the recipient in accordance with the terms and conditions of this Authorization, you 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 this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to you. The revocation will be effective immediately upon your receipt of my written notice, except that the revocation will not have any effect on any action taken by you in reliance on this Authorization before you received my written notice of revocation.

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 you 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