Attention Dr./Clinic/Hospital

AUTHORIZATION TO USE AND DISCLOSE HEALTH 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:
E.Jacob Simhaee, M.D._____
Address of recipient or where my health information should be delivered:

1201 Northern Blvd. Suite 300, Manhasset, NY 11030. Please fax only if chart is less than 5 pages. Fax #: 516-365-6308

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 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.

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