Central Park Endocrinology PC Gregory Dodell MD, Raya Galibov PA, Jimmy Vo MD
Richard R. Neufeld MD, Robert M. Romanoff MD, PC

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   ____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name

   Address

   City, State Zip Code
3. The specific information that should be disclosed is (please give dates of service if possible):

____

____

____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *_____________________
   NO, **DO NOT** DISCLOSE THIS INFORMATION * _____________________
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _______________________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for ____.
7. This authorization expires on _____________, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____________________________________.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with Health Port to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places. *

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or** **Social Security Number**

OR, if applicable –

Signature of Guardian* or **Personal Representative of Patient's Estate**	**Date of Guardian's/Personal** **Representative's Signature**	**Description of Authority to Act** **for the Individual**

A copy of this completed, signed, and dated form must be given to the Individual or other signatory.

Official Use Only

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