AUTHORIZATION TO RECEIVE OR DISCLOSE INFORMATION

I, _____ DOB_____,
(Fill in your name) (Fill in your full birth date)

authorize _____ to receive and/or disclose the specific health
(Fill in name of care provider who will be sharing information with Dr. Huberman)

information described below:

__Any applicable medical and/or mental health records
__Only records during the period from _____ to _____
__Verbal communication
__Written summary of records
__Other:_____

This information should be received from and/or disclosed to: Dr. Amy Huberman, fax: 443-420-9150, phone: 443-761-4265 for the purpose of (check all that apply):

__Continuity of care
__Coordination of care
__Other:_____

I have reviewed and understand this Authorization. I also understand that the information received or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

Patient: _____ Date:_____

Witness: _____ Date:_____

Notice: Your physician cannot make receipt of this signed Authorization a condition of treatment. You may inspect a copy of the protected health information in question, you may refuse to sign this Authorization, and your physician must provide you with a copy of the Authorization if you request one. You have the right to revoke this Authorization at any time, provided that you do so in writing, except to the extent that your physician has already received or disclosed information relying on this Authorization.

Expiration date

__When transfer of care is complete
__Other:_____