PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient: ____
(First Name) (Middle Initial) (Last Name)

Address: ____

Date of Birth: ____

Jerrold Rosenberg, MD is authorized to furnish to:

Name of Recipient : ____

For the Purpose of : ____
(optional)
____

MEDICAL RECORDS (Excluding Sensitive Information)

- ☐ Information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease beginning ____/____/______ and ending ____/____/______ and , if necessary, allow them or any physician appointed by them to examine any x-rays or other diagnostic records which the facility may have regarding my condition or treatment during this period.

- ☐ Only those specific records as described below :

____

____

SENSITIVE INFORMATION

- ☐ In addition, I hereby specifically consent to the disclosure and release of "sensitive medical information" concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug abuse/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, **if any**.

I release **Jerrold Rosenberg, MD** from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to **Jerrold Rosenberg, MD**, provided that you do so in writing and to the extent that we have already disclosed the information in reliance on this authorization.

This Authorization expires on ____/____/____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

______________________________ ______________________________
Patient Signature (Parent's Representative if minor) Date

______________________________ ______________________________
Witness Signature Date