

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