Alan D. Glassman, M.D., P.C.

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AUTHORIZATION to disclose or use my health care information

Patient Name(s):	Date(s) of Birth:

Street Address:

City:	State:	Zip:

OR:

You may GET health care information from: Name:	**You may SEND this health care information to:** Name:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:

You may disclose the following health information (check all that apply):

____ Copy of ALL Health Record(s)
____ Copy of Medical History/Immunization record(s)
____ Most recent office visit including lab results
____ Other (specify) _________________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Alan D. Glassman, M.D. is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Reasons for this authorization (check all that apply):

____ Sharing with other health care providers
____ Personal use
____ Transferring to another provider
____ Legal purposes
____ Other ____

This authorization will expire 90 days from the date it is signed unless I specify an expiration date. Date: ___________

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. A copy or facsimile of this authorization with my signature may be used with the same effectiveness as an original.

Parent or Guardian Signature: ____ Date: ___________________
(Or self if over the age of 18)

Witness Signature: ____ Date: ___________________