Patient's Authorization to Disclose Protected Health Information to the Practice of Dr. Rosenzweig

Patient's Name:	**Date of Birth:**

I authorize the following practice(s) to disclose my health information as described below to

Steven Rosenzweig, MD
123 Chestnut Street; Philadelphia, PA 19106
Fax: 888-802-0516; Tel: 215-627-3782

__ INCLUDE __ DO **NOT** INCLUDE any and all psychological and psychiatric information (separate authorization is required for psychotherapy notes)
__ INCLUDE __ DO **NOT** INCLUDE any and all drug and alcohol treatment information
__ INCLUDE __ DO **NOT** INCLUDE any and all HIV/AIDS related treatment information
__ INCLUDE __ DO **NOT** INCLUDE any and all genetic information

NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION

I understand that if I give permission, I have the right to change my mind and revoke it in writing. I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.

SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE	**DATE**

Authorized Health Representative's Name	**Relation to Patient**