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| **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  We are NOT requesting:  Psychotherapy notes  Drug and alcohol treatment reports  R I am giving permission to include (should this apply to me):  Information about HIV diagnosis and treatment  Information about genetic testing results | |
| NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY | TYPE AND AMOUNT OF INFORMATION  Recent and future progress notes and test reports |
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| 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** | |