David S. Weiss, MD

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Authorization for Use and Disclosure of Protected Health Information

This form provides authorization to David S. Weiss, MD ("the Practice") to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I, _____, (date of birth: _____ / _____ / _____) authorize the Practice to: (check one:)

☐ **Disclose to:**

☐ **Obtain from:**

(name:) _____

With an address of: _____

_____

_____

The following information:

_____

_____

_____

The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization. I understand that if my records contain information about alcohol and drug abuse, mental health treatment and/or HIV/AIDS status, I authorize the Practice to release such information as part of my medical record only if I place my initials on the appropriate line as set forth below.

Included in information to be released:

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV Related Information

Purpose of Information to be Disclosed:
[If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the purpose, the purpose shall be stated as "at the request of the individual"]**:**

_____

_____

_____

This authorization shall expire upon the earlier of (i) ____ days from the date of this request or (ii) the following date _____ or (iii) the occurrence of the following:

_____.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Practice's Privacy Officer, at:
David S. Weiss, MD
161 Madison Avenue – Suite 10NW
New York, NY 10016

I understand that a revocation is not effective to the extent that the Practice has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that the Practice will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ Signature of Patient	_____ Date

If the patient is a minor or is otherwise unable to sign this Authorization, please complete the information below:

_____ Signature of authorized Personal Representative	_____ Description of Authority	_____ Date