AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION TO BE RELEASED TO DAVID HERSON MD

I REQUEST_____
(Name of Provider TO DISCLOSE Information)

_____
(Address)

_____ _____
(Phone Number) (Fax Number)

TO RELEASE TO: David Herson MD
21756 State Road 54, Suite 102A, Lutz, FL 33549
Office phone: (813) 443-5817 Fax (813) 443-5818

THE FOLLOWING INFORMATION (Select any or all):

( ) My entire medical record held by the Provider, including, but not limited to, HIV/AIDS, mental health (excluding psychotherapy notes), substance abuse or genetic information.
( ) Progress Notes
( ) Diagnostic studies
( ) Procedures, surgeries
( ) All dates of care and treatment

FOR THE FOLLOWING PURPOSE: Treatment by Dr. Herson

THIS AUTHORIZATION WILL EXPIRE ON: _____
(If no date given, authorization will expire in ninety (90) days.)

SPECIFIC UNDERSTANDINGS:

I understand that I may revoke this Authorization at any time by notifying the Provider in writing, except to the extent that the Provider has taken action in reliance on this Authorization.
I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.
I understand that the information disclosed under this Authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations or other privacy laws.
I understand that by signing this Authorization I authorize the Provider to disclose the information identified above and related information necessary to accomplish the purpose described above.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority

Date of Birth_____
(A copy of this signed form will be provided to the patient or his/her personal representative)