

### Authorization for Release of Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I authorize Dr. Neal Mazer to release information to:

AND/OR

I authorize Dr. Neal Mazer to obtain information from:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone #/Fax # (Include area code)

\_\_\_\_\_  
Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one)  Healthcare  Insurance Coverage  Personal  Other

TYPE OF RECORDS AUTHORIZED:  Psychiatric/Psychological Evaluation and/or Treatment  
 Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

- Assessments  Progress Notes  Laboratory Test Results: \_\_\_\_\_
- Diagnostic Impression  Discharge Summary  Treatment Plans
- Treatment Summary
- Other: (please describe) \_\_\_\_\_

**One-time Use/Disclosure:** I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

- When the requested information has been sent/received.
- 90 days from this date.  Other: \_\_\_\_\_

**Periodic Use/Disclosure:** I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

**My authorization will expire:**

- When I am no longer receiving services from Dr. Neal Mazer.
- One year from this date.  Other: \_\_\_\_\_

**I understand that:**

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Dr. Neal Mazer, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if requester is not the patient):  Parent  Legal Guardian  Other: \_\_\_\_\_

Patient or Representative has been provided a copy of this authorization: \_\_\_\_\_

Dr. Neal Mazer