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INFORMED AUTHORIZATION/CONSENT TO RELEASE INFORMATION

PATIENT NAME:_____ DOB:_____

I hereby authorize Dr. Robert S. Patitucci, M.D. to:

To Obtain Information From:

Individual/Orgnaization:_____

Address:_____

Phone/Fax Number:_____

*This information is being disclosed under the authority, protection and provisions of applicable Federal law (including, but not limited to HIPPA and **42 C.F.R. Part 2). This authorization is only valid for the information, individuals and organizations cited above. These laws prohibit any further disclosure of this information, unless further disclosure is expressly permitted by written authorization by the person to whom it pertains or as otherwise permitted by regulation.

I understand that this release may or may not contain information pertaining to certain medical conditions. I do expressly and voluntarily authorize the disclosure of the above indicated information to the person(s) or entity(ies) as stated above. I also understand that this information may be released via the U.S. Postal Service, an overnight delivery service or by way of facsimile.

This consent is subject to revocation at any time except to the extent that action on the disclosure was already taken in reliance of it. If not previously revoked, this authorization/consent will expire in:

__45 days __90 days __180 days __365 days
(if no box is checked, this release will expire in 90 days)

_____ Date:_____
Patient, Parent, Guardian or Legally Authorized Persons

_____ Date:_____
Witness