Olga Zarkh, M.D., Your Personal Doctor

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Maiden/Other Name _____

Birth Date _____ Social Security # _____ Telephone Number _____

I hereby authorize_____, its Director or designee, to release information contained in the medical records of the patient identified above including any drug and alcohol abuse records in accordance with Federal Regulations and/or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases. **I specifically authorize the release of information regarding:**

_____Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or Acquired Immunodeficiency Related Complex (ARC).

The information may be released to the following:

1. NAME AND ADDRESS TO WHOM THE INFORMATION IS TO BE DISCLOSED:

_____

_____

_____

2. SPECIFIC INFORMATION TO BE DISCLOSED:_____
   Admit/Discharge Dates
   _____Summary Documents
   Other_____
   _____Entire Medical Record
   _____

3. PURPOSE AND NEED FOR SUCH DISCLOSURE:

   _____

4. **This consent is subject to revocation at any time except in those cases in which the Hospital has acted with the understanding that the consent will continue in effect until the stated purpose has been accomplished. However, any consent given with respect to substance abuse records shall have a duration no longer than is reasonably necessary to effectuate the purpose for** which it is given.

5. Without expressed revocation, this consent expires 90 days subsequent to signing, or on the date set forth below, or for the following specified reasons:
   Date:_____, or Event:_____
   Condition:_____

NOTE: A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

Signature of patient/legal representative _____ Signature of witness _____

Date signed _____ Date witnessed _____

Relationship to patient if not signed by patient

Indicate why patient is unable to sign: _____Minor _____Ward _____Deceased _____Other, explain below:

NOTE TO AUTHORIZING PARTY: There is the potential that the protected health information that we release subsequent to this authorization may be re-disclosed by the recipient and thus, would no longer be protected under the Health Insurance Portability and Accountability Act of 1996 (Privacy Rule).

NOTE TO RECEIVING AGENCY/PARTY: You may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.