Health Information Release Form

I, _____ hereby authorize Jeremy Barowsky, M.D. to disclose information and records obtained in the course of my diagnosis and treatment for the following purposes: to increase understanding of my diagnostic and treatment history; to coordinate care on an ongoing basis with my other treatment providers; or to discuss my care with friends or family who support me.

Information is to be communicated with:

Name of Individual/Organization Address Phone/Fax Numbers

1)_____

2)_____

3)_____

I understand that I have the right to revoke this authorization at any time. However, this authorization must be provided by me in writing, and received by Jeremy Barowsky, M.D. to be effective.

I understand that I am voluntarily signing this form to exchange health information with the party or parties designated above.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information. This authorization is effective immediately and shall remain in effect for one year from date of signing unless explicitly revoked in writing.

Signature: X_____ Date: _____

If parent or legal guardian:

Name:_____Relationship to Patient:_____

Witness:_____

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