MARLBORO INTERNAL MEDICINE
RELATIONSHIP ■ RESPECT ■ RESULTS

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient: _____ **Date of Birth:** _____

I hereby authorize medical providers and personnel of **Marlboro Internal Medicine** to discuss my protected health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
____ Psychotherapy notes from a Psychiatrist or Psychotherapist
____ Treatment for alcohol or drug abuse reports

This information shall be in force and in effect from_____ until _____ at which time this authorization to use or disclose this protected health information expires.

- Unless specified above, this authorization will expire 365 days from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
- 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 federal or state law.
- I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient / Personal Representative **Name of Patient / Personal Representative**

_____ _____
Date **Description of Personal Representative's Authority**