

AUTHORIZATION TO USE OR RELEASE PERSONAL HEALTH INFORMATION

1. I, \_\_\_\_\_, hereby authorize Alan Manevitz, M.D. to release the health care information described below to: [Individual or entity to receive information]

Name: \_\_\_\_\_

Entity: \_\_\_\_\_

Address: \_\_\_\_\_

2. This request and authorization applies to only the following protected health information: [Description should be as specific and detailed as possible]

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3. List each purpose or reason for the use or release of the protected health information:

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4. This authorization shall remain in full force and effect until

\_\_\_\_\_

[Expiration date or expiration event related to the individual or the purpose of use or disclosure]

5. I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to:

ALAN MANEVITZ, MD 60 SUTTON PLACE SOUTH SUITE 1CN, NEW YORK, NY 10022  
ATTN: ACCOUNTS

6. I understand that Dr. Alan Manevitz may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.

7. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from redisclosing any HIV-related information about you without your authorization unless permitted to do so by federal or state law.

8. I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

9. I understand that I have the right to refuse to sign this authorization.

Please sign below to authorize the use or release of your personal health information for the reasons set forth above:

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative, if applicable

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Patient's Personal Representative, if applicable

\_\_\_\_\_  
Description of Authority of Patient's Personal Representative if applicable