

# Authorization to Use or Release Personal Health Information

TMS Medical Associates of New York, PLLC, 60 Sutton Place South, Suite 1CN, New York, NY 10022, Tel: 212 935 1423 Fax: 212-935-1423  
ALAN MANEVITZ, MD <-> JAMES HALPER, MD

1. I, \_\_\_\_\_, Date of Birth: \_\_\_\_\_, SS No: \_\_\_\_\_ residing at \_\_\_\_\_, Tel: \_\_\_\_\_ hereby authorize TMS Medical Associates of New York, PLLC to release the health care information described below to:

**Name of Individual/Organization** (to receive information): \_\_\_\_\_

**Address:** \_\_\_\_\_ **Tel:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

2. This request and authorization applies to only the following protected health information:

*[Description should be as specific and detailed as possible]*

**Please Release the Following:**

\_\_\_\_\_ Problem List                      \_\_\_\_\_ MRI Reports and Films                      \_\_\_\_\_ History/Physical Exam  
\_\_\_\_\_ Progress Notes                      \_\_\_\_\_ CAT Scans Reports and Films                      \_\_\_\_\_ EEG Reports  
\_\_\_\_\_ Lab Reports                      \_\_\_\_\_ Psychological Test Reports  
\_\_\_\_\_ Other Diagnostic Reports (Specify) \_\_\_\_\_  
\_\_\_\_\_ Other (Specify) \_\_\_\_\_

**Including information (if applicable) pertaining to:**

\_\_\_\_\_ Mental Health    \_\_\_\_\_ Drug/Alcohol    \_\_\_\_\_ HIV/AIDS    \_\_\_\_\_ Communicable Treatment

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

\_\_\_\_\_ Continued Patient Care    \_\_\_\_\_ Personal Use    \_\_\_\_\_ Disability Determination  
\_\_\_\_\_ Attorney/Legal    \_\_\_\_\_ Insurance Claim/Application  
\_\_\_\_\_ Other (Specify) \_\_\_\_\_

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:

*TMS Medical Associates of New York, PLLC  
60 SUTTON PLACE SOUTH SUITE 1CN, NEW YORK, NY 10022 Attn: ACCOUNTS*

6. I understand that TMS Medical Associates of New York, PLLC 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**