Neil S. Rosenthal, MD., PC
201 East 15th Street
New York, NY 10003

Patient Authorization: For Use and Disclosure of Protected Health Information

RE: Patient Name: _____ Patient Date of Birth: _____/_____/_____

I, _____, [print name] hereby authorize Neil S. Rosenthal MD, PC, and its physicians and staff (the "Practice") to use and disclose my (the patient's) individually identifiable Protected Health Information, which may include demographic and physical health information and related health care services, including [cross out items *not* to be disclosed]: mental health information, HIV-related information, sexual history (including any sexually transmitted diseases), and drug and alcohol use.

Name, address, telephone number and relationship to patient of person(s) (including family and friends) to whom the Practice is authorized to release (via fax, phone, mail, email, secure messaging, or in person) the Protected Health Information described in the sections below concerning me (the patient):

_____

_____

_____

_____

_____

I understand and accept that this information may include details about my (the patient's) history of drug and/or alcohol use, sexual orientation, and HIV status. All facilities/persons listed on this authorization and the Practice may share information among and between themselves for the purpose of providing medical care.

Specific Purpose of the Disclosure

It is at the request of myself (the patient), or if otherwise, indicate other specific purpose of the disclosure here:

_____

_____

Description of the Information that is to be Disclosed

Any or all medical records from first date of service until eventual last date of service, or if otherwise, the specific information (including dates) specified below:

_____

_____

_____

_____

Expiration Date for this Authorization

Until authorization is revoked in writing by myself (the patient), or if otherwise, the following specific expiration date or event: _____

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2493, or the New York City Commission on Human Rights at **212-306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to sign this form or allow release of medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the Practice, however, such revocation does not affect any action taken by this Practice based on this authorization before any such revocation. I also understand that (1) when the information is disclosed as per this authorization, it may be subject to redisclosure by the recipient, and may no longer be protected under the federal HIPAA Privacy Rule, nor by other applicable state and federal laws, (2) I may see and copy the information on this form, and get a copy of this form after it is signed, and (3) the Practice will not condition any treatment on whether I authorize the above disclosure of Protected Health Information.

Signature of patient (or patient's legal power of attorney): _____ Date_____

Printed name of patient's legal power of attorney: _____ Relationship_____