MAPLE MEDICAL, ™LLP

Pulmonary, Critical Care, Internal Medicine, Endocrinology, Cardiology & Nephrology

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

(Note: This form cannot be used to authorize a release of HIV-related information)

Patient Name: _____ _____ _____

Last First Middle

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: _____

_____

RECIPIENT: Send To: _____ Address: _____

City & State: _____ Zip Code: _____

TERM: This Authorization will remain in effect:

- o From the date of this Authorization until the _____ day of _____ 200____
- o Until the following event occurs:_____

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this authorization:

Patient Signature: _____ Date: _____

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that this authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Office Manager. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

The address of the Office Manager is 170 Maple Avenue, Suite G1, White Plains, NY 10601 I may contact the Office Manager by telephone at (914) 328-0932.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Signature of Patient: _____ Date: _____

Signature of Authorized Rep. / Guardian: _____Title: _____Date:_____