Kathryn Eckstein Jalovec, M.D.

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Health Information Release Form

Consent & Authorization to Use, Disclose and Receive Medical and Mental Health Information.

I, _____ ,
(Patient Name – First Name Last Name Any Known Alias)

hereby authorize Kathryn Eckstein Jalovec, M.D., to disclose information and records obtained in the course of my diagnosis and treatment, and to receive information about my diagnosis and treatment for the following purpose: to increase understanding of my previous history, diagnosis, and treatment; to coordinate care on an ongoing basis with other providers that are also treating me; or to discuss my care with friends or family that may be important sources of support.

Information is to be disclosed to:

Name of individual/organization	Address	Phone number/Fax
1) _____	_____	( ) _____
2) _____	_____	( ) _____
3) _____	_____	( ) _____

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by Kathryn Eckstein Jalovec, M.D., to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and signing of this authorization and that Kathryn Eckstein Jalovec, M.D., shall not condition my treatment or the treatment of those under my care upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

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 the HIPAA Privacy Rule, although applicable state laws may protect such information. This authorization is effective immediately and shall remain in effect for one year from date of signing unless explicitly revoked in writing.

Signature: X_____ Date: _____
(patient, parent, or legal guardian)

If parent or legal guardian: _____

Name: _____ Relationship to client: _____

Witness: _____