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AUTHORIZATION TO RECEIVE OR DISCLOSE INFORMATION

I, _____, date of birth _____ authorize Dr. Renee Kohanski to receive and/or disclose the specific health and medical information described below:

X Any applicable medical and/or psychiatric records

This information should be received from and/or disclosed to: Dr. Renée Kohanski for the purpose of

and from _____

X Continuity of care

X Coordination of care

I have reviewed and understand this Authorization. I also understand that the information received or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

Patient: _____ Date:_____

Witness: _____ Date:_____

Notice: I cannot make receipt of this signed Authorization a condition of treatment You may inspect a copy of the protected health information in question, you may refuse to sign this Authorization, and I must provide you with a copy of the Authorization if you request one. You have the right to revoke this Authorization at any time, provided you do so in writing, except to the extent that I have already received or disclosed the information relying on this Authorization. Unless otherwise specified, this Authorization will expire when transfer of care is complete.