AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Ruth H Steinman, MD; 191 Presidential Blvd; Suite 111A; Bala Cynwyd, PA 19004

PATIENT NAME:____

DATE OF BIRTH: ___/_____/______

1. I authorize the use or disclosure of the above named individual's information described below.
2. The following individual(s) or organization(s) are authorized to make this disclosure: The office of Ruth Steinman, MD
3. The information identified below may be disclosed to or used by the following individuals or organizations:____
4. The type of information that may be disclosed is as follows (check those that apply):
   a. Diagnostic and medical history
   b. Entire record
   c. Summary only
   d. Other (please give specific description)____
5. Specifically protected information (check those that apply):
   a. I understand that the information to be disclosed may include information relating to HIV/AIDS.
   b. I understand that the information to be disclosed includes mental health information and information about the treatment for drug, alcohol and substance abuse.
6. This information for which I am requesting disclosure will be used for the following purpose:
   a. My medical treatment
   b. Insurance payment/reimbursement
   c. My personal use
   d. To evaluate my eligibility for life insurance coverage
   e. To evaluate my eligibility for disability benefits
   f. At the request of my attorney
   g. Other (please describe):____________________________________
7. I understand that I have the following rights:
   a. The right not to sign. You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by the office of Ruth H Steinman, MD, except when health services are solely for the purpose of reporting to a third party.
   b. Right to revoke. You may revoke this authorization at any time. Your revocation will not apply to any release already made in response to this authorization. To revoke this authorization, you must submit a written revocation to Ruth H Steinman, MD.
   c. Re-disclosure. I understand that once the information listed above has been disclosed, it could potentially be re-disclosed because the information may no longer be protected by federal privacy laws and regulations.
8. Expiration date or event:____

I have read and understand this authorization and authorize the use and/or disclosure of the health information as described in this authorization.

Signature of patient (or parent, legal guardian, or other legally authorized representative)

Name of personal representative and relationship to patient:

Date:_________________________________