AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

Patient Name: _____

Date of Birth: _____

I authorize the use or disclosure of the above named individual's information described below:

1. The following individual(s) or organization(s) are authorized to make this disclosure to each other and/or use the health information: The office of Ruth Steinman, MD and _____.
   _____
   _____

2. The type of information that may be disclosed is as follows:
   a. Entire record
   b. Summary only
   c. Other: _____

3. Authorization for communication is via:
   a. Written records
   b. Two way communication

4. Specifically protected information:
   a. I understand that the information to be disclosed may include information related 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.

5. The information for which I am requesting disclosure will be used for the following purpose:
   a. My medical treatment
   b. Insurance and/or disability issues
   c. My personal use
   d. At the request of my attorney
   e. Other (please describe): _____

6. 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.

SIGNATURE: -

_____

DATE: _____