LONG ISLAND
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Authorization to Use or Release Protected Health Information

1. Patient Name_____ **Date of Birth** _____
(please print)

____ **I authorize:** Frank G. Dowling, MD – Rachna Sharma, MD – Marsha Alexander, DO
Peter Smith, NP – Gabrielle R. Chiaramonte, PhD – Jenny Hwang, Ph.D.
Linda McLehose, LCSW-R – Leah Schneider, LCSW – Kelly Stanley, LMSW
to **RELEASE** Protected Health Information **TO**:

_____

_____

____ **I authorize:** Frank G. Dowling, MD – Rachna Sharma, MD – Marsha Alexander, DO
Peter Smith, NP – Gabrielle R. Chiaramonte, PhD – Jenny Hwang, Ph.D.
Linda McLehose, LCSW-R – Leah Schneider, LCSW – Kelly Stanley, LMSW
to **OBTAIN** Protected Health Information **FROM**:

_____

_____

2. Extent or nature of information to be disclosed, including dates of treatment:

Medical, psychiatric and substance abuse history, treatment history, work and social functioning;

_____

3. Purpose or Need of Such Disclosure:

___ Coordination of Treatment ___ Insurance ___ Legal Purposes

___ Other: _____

4. This authorization shall remain in full force and effect until _____ (or one year from today if not otherwise stated).

5. I understand that, except with respect to action already taken in reliance on authorization, I may revoke this authorization at any time by delivering or sending written notification to:

Long Island Behavioral Medicine, P.C.
1727 Veteran's Memorial Hwy, Suite 300
Islandia, NY 11749
Phone 631-656-0472 Fax 631-656-0634

(or to person/facility noted above if release is to obtain information)

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6. I understand that my physician or staff may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.

7. I understand that information released from this office pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws (for example, an employer).

If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from re-disclosing any HIV-related information about you without your authorization unless permitted to do so by federal or state law.

8. I understand that I have a right to see a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

9. I understand that I have the right to refuse to sign this authorization.

Please sign below to authorize the use or release of your personal health information for the reasons set forth above. If the patient is unable to sign, please indicate the authority of the person who is signing for the patient.

Date	Signature of patient/representative	Print name

Relationship to patient

Date	Signature of Witness	Print name

If patient is under 18 or unable to legally make healthcare-related decisions on their own behalf for any reason, the following section must be completed by a Parent, Guardian, or Personal Representative with the legal authority to make healthcare-related decisions on behalf of the patient.

I, _____, having the legal authority to make healthcare-related decisions on behalf of _____, authorize the use or release of his/her personal health information for the reasons set forth above:

Signature _____ Date _____

Description of Authority of Patient's Personal Representative

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www.LongIslandBehavioralMedicine.com