JOHN J. BENJAMIN DAVIDMAN, M.D.
560 BROADWAY, SUITE 510
NEW YORK, NY 10012
212-219-0046

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

Name of patient:_____

Date of birth: _____

If patient is a minor (under age 18), this form must be completed and signed by parent or legal guardian. Enter name of person completing this form and relationship to patient if that is the case:

Name of parent/guardian:_____

Relationship: _____

Address of patient/family:_____

Phone:_____

In signing below I authorize the following treatment facility:

Name of treatment facility or clinician:_____

Address: _____

City: _____**State:** _____

Phone:_____

To release the following information (check all that apply):

□ Psychiatric Records _Diagnostic & Laboratory Testing

□ Psychological Testing _Conversation between clinicians

□ Substance abuse treatment _Conversation with family/friend

□ Records of Psychiatric Hospitalization Other_____

□ Medical Records

To: **Dr. John J. B. Davidman, M.D. 560 Broadway, Suite 510, New York, NY 10012**

The purpose of this disclosure is for treatment and continuity of care.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the treatment facility or clinician named above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

This authorization will expire on _____ (if no date is entered it will expire in 12 months from the date signed).

Signature of patient, or of parent/legal guardian if patient is a minor:

Signed: _____Print Name: _____ Date _____