TALIA WIESEL, Ph.D.

Address
Email:
Tel:

Request / Authorization to Release Confidential Records and Information

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip Code:_____

I hereby authorize the release of my protected health information to and from the following doctors/entities:

1. Talia Wiesel, Ph.D.
   163 Engle Street, Building #2
   Englewood, NJ 07631
   Tel:
2. Person or facility: _____
   Address: _____
   Tel: _____ Fax: _____
3. Person or facility: _____
   Address: _____
   Tel: _____ Fax: _____

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Other _____

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I/my child have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV). If I am authorizing the release of HIV-related information, the recipient(s) is prohibited from re-disclosing any HIV-related information without my authorization unless permitted to do so under federal and state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. [If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/(212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.]

By signing this authorization form, I am authorizing the use or disclosure of my/my minor child's protected health information as described above. This information may be re-disclosed if the recipient(s)as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed.

_____ _____

Patient / Representative Signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____