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(302) 992-0200

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**AUTHORIZATION TO TRANSFER AND/OR DISCLOSE HEALTH INFORMATION**

Patient Name _____ Date of Birth_____
I authorize the use of disclosure of the above named individual's health information by the following individual or organization.

_____

(Requesting from: Name of previous facility and/or physician) (Phone number)

_____

(Address, city, state, zip) (Fax #)

The information may be disclosed to and used by the following physicians:
Rebecca Jaffe, M.D., Julie Prosseda, M.D., and Bipasha Mitra, M.D.
3105 Limestone Road Suite 300, Wilmington, De 19808

**The type and amount of information to be used or disclosed is as follows:**

| | | |
|---|---|---|
| **___ Office notes** | **_____ EKG** | **_____ ALL RECORDS** |
| **___ Labs** | **_____ Reports** | **_____ Other: _____** |
| **___ Radiology Reports** | **_____ Last Office Note** | **_____** |

**For the purpose of:**
**___Continuing Care, ___Consultation, ___Attorney, ___ Disability, ___Insurance, ___other (specify) _____**

**I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include informations about behavioral or mental health services, and treatment for alcohol and drug abuse.**

**I understand that I have the 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 health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.**

**I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIPPA compliance officer at Rebecca Jaffe and Associates.**

**Signature of Patient or Legal Representative: _____**

Date: _____ Patient's Social Security #: _____

If not signed by patient, please specify reason: _____

Witness to signature: _____ Date: _____