RAHIM N. RAHEMTULLA, M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Authorization to Obtain, Use, and Disclose Protected Health Information

Patient Name: _____
last *first* *middle*

Home Address: _____

_____
city *state* *zip*

Home Telephone: _____ Date of Birth: _____

I authorize Rahim Rahemtulla, MD and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment, or coordinating care unless specified otherwise below.

Name/Facility: _____
(e.g. PCP, therapist)

Address: _____

_____
city *state* *zip*

Office Telephone: _____ Fax Number: _____

Information Covered Under This Release: (INITIAL wherever appropriate)

____ Entire medical record
(e.g., discharge summaries, lab data, and information from a primary care physician)

____ Ongoing communication regarding psychiatric or mental health care
(e.g., ongoing care with a primary care physician or mental health provider)

____ Information regarding the academic or behavioral performance of child in school
(e.g., ongoing communication with teachers, school psychological testing, Individual Education Plans)

____ Psychological testing

____ Information for referral purposes

____ Other (please specify) _____

220 FIFTH AVENUE, SUITE 300/OFFICE #7, NEW YORK, NY 10001
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Highly Confidential Information

____ Specific authorization for information related to testing, diagnosis and treatment for drug or alcohol use

____ Specific authorization for information related to testing, diagnosis and treatment of sexually transmitted diseases or HIV

The purpose of this disclosure is:

Medical care:_____ Legal Matter:_____ Insurance:_____ Personal:_____

This authorization expires:

____ Termination of treatment with Dr. Rahemtulla

____ 90 days from the date signed

____ On specified date, reason or event (specify) _____

By my signature below, I hereby authorize Rahim Rahemtulla, MD to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization). I understand that once Rahim Rahemtulla, MD discloses my health information to the recipient, Rahim Rahemtulla, MD cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Dr. Rahemtulla's treatment of me; except, however, if my treatment by Dr. Rahemtulla is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Dr. Rahemtulla may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Rahim Rahemtulla, MD. the revocation will be effective immediately upon Rahim Rahemtulla, MD's receipt of my written notice, except that the revocation will not have any effect on any action taken by Rahim Rahemtulla in reliance on this Authorization before he received my written notice of revocation.

I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize Rahim Rahemtulla, MD to obtain use and/or disclose my health information in the manner described above.

Signature of Patient (or Parent/Guardian if minor) Relation Date

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