II. Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Dr. Aronson-Ramos, M.D. and affiliated staff members to use and/or disclose certain protected health information (PHI) about

_____ to the following individuals
(Please list the individuals and their phone numbers you would like to include, for example, MDs, speech or occupational therapists, specialists, psychologists, teachers, etc.)_____
_____
_____
_____

This authorization permits Dr. Aronson-Ramos, M.D. to use and/or disclose to or obtain from other designated professionals specified individually identifiable health information about the above named patient including but not limited to medical records, reports, and progress notes related to diagnoses, comprehensive medical history, treatment plan, and prognosis. Additional information may include: report cards, progress reports, educational testing, direct interview and any other information deemed appropriate by the specified individuals contacted and/or Dr. Aronson-Ramos.
The information will be used or disclosed for the purpose of continuity of care, diagnosis, and direct treatment planning.

Under certain circumstances Dr. Aronson-Ramos may be required by law and her professional duty to disclose information that could result in harm to the patient and/or others to certain state agencies.

The purposes are provided so that I can make an informed decision whether to allow release of the information. This authorization will only expire by written consent or formal termination of treatment. I do not have to sign this authorization in order to receive treatment from Dr. Aronson-Ramos. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted directly to: Dr. Judith Aronson-Ramos, M.D.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian Relationship to Patient Date

Witness: _____ Date: _____

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