Brad K. Greenspan, MD

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AUTHORIZATION FORM

This form, when completed and signed by you, authorizes the release/sharing of protected medical information from your clinical record to the person(s) you designate:

I, ___________________________________, authorize that information regarding my treatment with Dr.
Patient Name

Greenspan may be shared/reciprocal with the following individuals:

Name	Address	Telephone
______________________	______________________	____________
______________________	______________________	____________

Information disclosed may be related to the following medical issues. Check all that apply:

- ☐ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/AIDS records
- ☐ Mental health treatment records
- ☐ Alcoholism treatment records
- ☐ Drug abuse treatment records
- ☐ Psychological/Neuropsychological Testing report only
- ☐ Other:____

This authorization shall remain in effect until _______________ (if no calendar date is provided, information may be released/shared for the period of one year).

You have the right to revoke this authorization, in writing, at any time, by sending such written notification to Dr. Greenspan. However, your revocation will not be effective to the extent that the information was already released according to this authorization.

I understand that I will not be refused treatment if I refuse to sign this authorization, unless the treatment is provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed medical information at any time.

___________________________________ ____________________
Patient (if 12-18 years of age) Date

___________________________________ ____________________
Patient Signature Date