AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENTS NAME: _____ **DOB:**_____

BY SIGNING THIS AUTHORIZTION , I AUTHORIZE ROSEMARY DELGADO , M.D. , INC. TO RELEASE AND OR RECEIVE HEALTH CARE INFORMATION ABOUT MYSELF TO / FROM

NAME: _____

ADDRESS: _____

_____

_____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING HEALTH INFORMATION:

TREATMENT / CONDITION OF _____
ALL HEALTHCARE INFORMATION
OTHER _____

THIS AUTHORIZTION APPLIES TO THE FOLLOWING PROTECTED HEALTH INFORMATION:

I specifically authorize the release of protected health information (PHI) including testing, diagnosis and / or treatment related to the following:

- Acquired Immunodeficiency Syndrome (AIDS) or the Human Immunodeficiency Virus (HIV)
- Sexually Transmitted Diseases
- Substance Abuse Drug or Alcohol
- Mental Health, Behavior, or Psychological / Psychiatric Care or conditions

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID FOR 90 DAYS UNLESS I REVOKE THIS AUTHORIZATION THROUGH WRITTEN NOTICE TO ROSEMARY DELGADO, M.D., INC.

_____

Signature of Patient / Authorizer Name Date

- $25.00 Copy Fee for all Records
- Prompt payment will help ensure processing