Jeffrey P. Kahn, MD
Suite 1J
45 Popham Road
Scarsdale, NY 10583

Phone: 914-725-6303

AUTHORIZATION TO USE OR RELEASE PERSONAL HEALTH INFORMATION

Patient Name _____

Patient Address _____

Patient Phone _____

1. I hereby authorize **Jeffrey P. Kahn, MD** to release and to receive the health care information described below to (and from):

   Name/Phone _____

   Entity _____

   Address _____

2. This request and authorization applies to the following health information:
   Full written and verbal medical record & information (except as specifically excluded)
3. List each purpose or reason for the use or release of the protected health information:
   Medical Care
4. This authorization shall remain in full force and effect for: **One Year.**
5. I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to Jeffrey P. Kahn, MD.
6. I understand that Dr. Kahn may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization (unless my treatment is related to research and the purpose of this authorization is specifically related to the research project).
7. I understand that information disclosed pursuant to this authorization could be subject to re-disclosure by the recipient if required by law or by a further medical information release.
8. I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.
9. I understand that I have the right to refuse to sign this authorization.

X _____
Signature of Patient (or Legal Guardian, or Minor Patient's Parent)

_____ _____
Name of Patient (or Legal Guardian, or Minor Patient's Parent) Date