

# Authorization for Kathleen Rein, M.D., PLLC to Use or Disclose My Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

## **I. My Authorization**

**You may use or disclose the following health care information (check all that apply):**

- All my health information maintained by Kathleen Rein, M.D., PLLC (except psychotherapy notes)
- My health information relating to the following treatment or condition: \_\_\_\_\_
- My health information for the date(s): \_\_\_\_\_
- Psychosocial Information  Alcohol and Drug Abuse Treatment Information  Psychotherapy Notes

**You may disclose this health information to:**

1. Name and organization \_\_\_\_\_ Phone/Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_
2. Name and organization \_\_\_\_\_ Phone/Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_
3. Name and organization \_\_\_\_\_ Phone/Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_

**Reason for this authorization (check all that apply):**

- At my request  Other (specify): \_\_\_\_\_

**This authorization ends:**  On (date) \_\_\_\_\_  When the following event occurs: \_\_\_\_\_

## **II. My Rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Kathleen Rein, M.D., PLLC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I need to write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient signature Date \_\_\_\_\_ Time \_\_\_\_\_

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