LUCIE M. TAUSTINE, PH.D.

218 Granny Road
Farmingville, NY 11738
Phone: 516.799.3320
Fax: 516.453.6798

CONSENT FOR RELEASE OF PATIENT INFORMATION

Patient's Name _____

Complete Address _____

Phone Number (_____)_____ Date of Birth _____

I, _____, acting on behalf of _____,

do hereby give consent to the disclosure to/from Dr. Lucie M. Taustine to/from:

Name _____ Phone Number _____

Complete Address_____

Nature/extent of information to be disclosed: _____

Purpose or need for disclosure: _____

This consent shall be valid for one (1) year from the date of signed authorization or until it is revoked in writing, whichever comes first.

Signed _____ Date _____

_____
Signature and Printed Name of Witness