Jodi Rubin, ACSW, LCSW, CEDS

10 West 15th Street, New York, New York 10011

Authorization to Obtain/Release Health Care Information

Client name: _____ Date of birth: _____

Address: _____

Please release health care information to:

Name and Organization: _____

Phone Number: _____ Email Address: _____

Address: _____

I authorize Jodi Rubin to obtain and release all health care information for the coordination of care and treatment with the above person and organization.

Once Jodi Rubin gives out the information, she has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for: HIV (AIDS virus), Sexually transmitted diseases, Psychiatric disorders/mental health, or Drug and/or alcohol use.

_____ _____

Patient or legally authorized individual signature Date

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative,

etc.: _____