Andrew Kopelman, MD
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Phone: (212) 255-5387

Authorization for Release of Information

Patient's name: _____

I hereby authorize Dr. Andrew Kopelman, MD, to contact and obtain and/or provide my medical history and other related information from/to the following people:

Name:	Telephone:
_____	_____
_____	_____

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke the above authorization at any time.

Signature: _____

Printed Name: _____

Date: _____

NOTICE OF CONFIDENTIALITY

It is understood and agreed to by the recipient of the document or communications requested above that this is privileged information within the doctor-patient relationship, and is confidential material by law. Further disclosure or release of the documents or their contents by the recipient of any other party is not authorized without the above patient's written consent. Furthermore, it is understood that the patient may withdraw his/her consent to this release at any time.