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MUTUAL EXCHANGE OF INFORMATION

PATIENT NAME:_____**DOB**_____

I AUTHORIZE MUTUAL EXCHANGE OF INFORMATION BETWEEN LEONID REMENSON, M.D., P.A. AND:

NAME_____

ADDRESS_____

_____

_____

PHONE_____FAX _____

REASON FOR DISCLOSURE_____

I UNDERSTAND THAT THIS AUTHORIZATION RELEASES MY GENERAL MEDICAL INFORMATION AS WELL AS INFORMATION CONCERNING MY PSYCHIATRIC TREATMENT. I ALSO UNDERSTAND THAT IF MY MEDICAL INFORMATION CONTAINS TREATMENT NOTES, DIAGNOSIS AND/OR TEST RESULTS OF **ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), HIV** AND /OR RELATED CONDITIONS, AND/OR SUBSTANCE ABUSE, THESE MEDICAL RECORDS SHALL ALSO BE RELEASED.

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE MY CONSENT AT ANY TIME BY DELIVERY OF WRITTEN NOTICE TO THE PROVIDER RELEASING THE INFORMATION. CANCELLATION WILL BE EFFECTIVE UPON THE DATE OF THE NOTICE IS RECEIVED BY THE PROVIDER BUT WILL EXCLUDE THE INFORMATION ALREADY FURNISHED TO THE RECIPIENT BEFORE THE DATE. IN THE ABSENCE OF MY WRITTEN NOTICE, THIS CONSENT SHALL BE REVOKED AUTOMATICALLY ONE YEAR AFTER THE DATE OF CONSENT AS IT APPEARS BELOW.

Signature of Patient or Legal Representative **Date**

Relationship to Patient (if Legal Representative)

Signature of Witness **Date**

To recipient of information: This information is disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations, CRF Part 2 and Florida statutes prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.