Haidar, Almhana & Nieding LLC dba
Quest Therapeutics of Avon Lake
223 Miller Rd
Avon Lake, OH 44012
P 440.930.2002 F 440.930.2085

Authorization to Disclose/Release Information

1. Patient Information	
Name	**Date of Birth**
Address	**City State Zip**
Phone	**Email**

2. Receive or Release Information	
Provider/Facility OR Family Member/ Friend	
Address	**City State Zip**
Phone	**Fax**

3. Purpose of Disclosure of Information (check all that apply)

	Continuity of Care		**Family/Friend Support**		**Financial/Payment purpose**
	Legal Purpose		**Emergency Situations**		**Other**

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health information.

I, understand that my records or information about my mental health or alcohol/drug abuse treatment and counseling are confidential: they are protected by applicable state and federal laws, and can not be disclosed or re-disclosed without written consent, unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV Infections, AIDS Related Complex, counseling, and the performance of any test/results cannot be released without my authorization. I understand that I may revoke this consent at any time.

This Authorization and consent will expire One Year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Haidar, Almhana & Nieding, LLC. Any revocation will not apply to information that has already been released in response to this authorization.

If Patient Revoke this release of information at any time, _____
Date **Initial**

_____
Signature of Patient/Guardian Date

_____
Patient Printed Name Relationship if not Patient