

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name:

Date of Birth:

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual/organization/facility is authorized to make the disclosure:
3. The type of information to be used or disclosed is the entire medical or no-fault file including copies of any x-rays or other diagnostic scans.
4. I understand that the above file may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or behavioral or mental health services, and treatment for alcohol and drug abuse.
5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: Bruno Gerbino & Soriano, LLP,
Address: 445 Broad Hollow Road, Melville, NY, 11747

Name:
Address:

6. This information for which I am authorizing disclosure will be used for litigation.
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present it to the above entity. I understand that the revocation will not apply to information that has already been released in response to this authorization and that the revocation will not apply to my insurance company when the law provides it with the right to contest a claim under my policy.
8. This authorization will expire on

Signature of patient or legal representative

Date

Signature of witness

Date