Douglas J. Abeles, M.D.

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Authorization to Discuss Medical Information

Patient Name:_____ Date of Birth:_____

☐ I do not give consent for any of my medical information to be disclosed

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

☐ Appointment Date/Times ☐ Diagnosis ☐ X-Ray/MRI Results ☐ Medications

☐ Summary of Medical Record ☐ All information pertaining to my medical care

☐ Other (please specify): _____

Information to be given to:

Name/Relationship:_____ Phone Number:_____

Name/Relationship:_____ Phone Number:_____

This authorization shall remain in effect from the date signed below until (please check one):

☐ NO EXPIRATION DATE

☐ _____ (specify expiration date or event)

I understand that:

- I may revoke this authorization in writing by contacting your office.
- This authorization is giving Douglas Abeles, MD Inc. the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by HIPAA.

Signature:_____ Date:_____