



Michael O Tanzer, MD 65 Broadway, Suite 739, New York, NY 10006
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Medical Release Form

Date: _____

By signing this authorization, I authorize Michael Tanzer, M.D. to receive/use and/or disclose the following protected health information (PHI) about me to:

(Name of entity to receive this Information)

(Address of entity to receive this Information)

Phone:Fax:

For the purpose of _____
(ie. Continuity of care, at the request of the individual, disability, employment, etc)

This authorization permits Michael Tanzer, MD. to receive/use and/or disclose the following individually identifiable health information about me

- () Any psychiatric information including notes, diagnosis, dates of service, etc.
- () Summary report of psychiatric treatment
- () Complete Medical/Psychiatric record (written/verbal documentation) including urinary drug screen results.
- () Other (please specify) _____

I release you from all legal responsibilities or liabilities that may arise from this authorization. This authorization expires on _____ (**unless there is a date written in the space provided, THIS RELEASE is valid for one year from the date printed below**). When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I do not have to sign this authorization to obtain treatment.

If this form is a release for Dr. Tanzer to give information about me to a new therapist or doctor, I give that therapist or doctor permission to call me to arrange the first appointment.

No Yes Patient's Initials _____ Contact Number _____

Signature of patient or legal guardian

Date

(Patient Name- Please print)

Signature witnessed by: _____ Date: _____

To revoke this authorization you must submit a request in writing to the address above.