John Panzone Psychiatry
1133 Pleasantville Rd, Suite 2A
Briarcliff Manor, NY 10510
Phone 914-715-1218
Fax 914-238-1697

RELEASE OF INFORMATION

1. I authorize the sending and receiving of information between Dr. John Panzone and the following providers:

   _____

   _____

   _____

   _____

2. For which of the following do you authorize the transfer of information:
   - ___ Mental health records
   - ___ Medical records
   - ___ Communicable diseases (including HIV/AIDS)
   - ___ Alcohol/drug abuse treatment
   - ___ Other (describe) _____

   This information may be used by the recipient for treatment, consultation, billing, claims, payment, or other purposes as I may direct.

   I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

   I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

   I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

3. For how long should this authorization be in effect:
   - ___ Indefinitely
   - ___ Until treatment is completed
   - ___ Other (describe) _____

Your signature acknowledges that you have read the above statement and agree to these conditions.

_____Date_____

Patient Signature

_____

Print name