Authorization for Kathleen Rein, M.D., PLLC to Use or Disclose My Health Information

Patient Name: ____ Date of Birth: ____________________

Previous Name: ____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by Kathleen Rein, M.D., PLLC (except psychotherapy notes)

☐ My health information relating to the following treatment or condition: ______________________

☐ My health information for the date(s): ____

☐ Psychosocial Information ☐ Alcohol and Drug Abuse Treatment Information ☐ Psychotherapy Notes

You may disclose this health information to:

1. Name and organization ________________________________ Phone/Fax: _________________

Address: ____________________________________ City __________________State___ Zip ____

2. Name and organization ________________________________ Phone/Fax: _________________

Address: ____________________________________ City __________________State___ Zip ____

3. Name and organization ________________________________ Phone/Fax: _________________

Address: ____________________________________ City __________________State___ Zip ____

Reason for this authorization (check all that apply):

☐ At my request ☐ Other (specify): ________________________________

This authorization ends: ☐ On (date) _______ ☐ When the following event occurs: ______________

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Kathleen Rein, M.D., PLLC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I need to write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ Date __________________ Time _______________

Patient signature

KATHLEEN REIN, M.D., PLLC
876 Park Avenue, Suite 1C • New York, NY 10075
16 School Street, Suite B • Rye, NY 10580
Phone: (212) 988-8809 • Fax: (212) 457-5650 • kathleenreinmd.com