AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ **Date of Birth:**_____

Address: _____
Street **City** **State** **Zip Code**

1. I, the undersigned patient, hereby authorize the disclosure and sharing of information described below between my healthcare practitioner David Gerard, J.D., Ph.D., New York License No.: 018178 (646) 355-8037, (the "Practitioner") and

_____
Provider Name & Title Name of Organization

_____
Street City State Zip Code

2. The information to be disclosed and shared:

3. This information is being disclosed and shared for the following purposes:

4. This authorization shall remain in full force and effect until one of these events occurs:

   _____ a. ninety (90) days after the date below
   _____ b. one (1) year after the date below
   _____ c. termination of treatment between the Practitioner and the Patient

5. I have the right to revoke (take back) this authorization at any time by providing written notification of my revocation to the Practitioner at the address above or his current address if it has changed. I am aware that my revocation will not be effective if the Practitioner has already taken action because of my earlier authorization.
6. I understand that information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by privacy laws.
7. I understand that I do not have to sign this authorization and that my treatment will not be conditioned upon whether I sign this authorization except in unusual circumstances.
8. I authorize that a photocopy or facsimile copy of this release shall be considered as effective and valid as the original.
9. I authorize my information to be faxed or electronically transmitted between the parties indicated above, and understand the limits of confidentiality which doing so creates.

I have read and fully understand the above statements and consent to the disclosure of the information described above for the purpose and to the extent stated above.

_____
Signature of Patient or Patient's Representative Today's date

_____
Print Name of Patient or Patient's Representative Today's date