AUTHORIZATION TO EXCHANGE HEALTHCARE INFORMATION

_____ _____

Patient Full Name **Date of Birth**

_____ _____

Date of Authorization **Day time phone / mobile phone**

I understand that my medical and mental health information and records are protected by Federal and State confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon it.

I understand that my right to confidentiality under Federal law and regulations does not protect any information about a crime committed or suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical, bodily harm, or that anyone else is in danger of physical, bodily harm, that information is not protected under Federal regulations.

I understand that information about HIV/AIDS, sexually transmitted disease, mental health, and drug or alcohol treatment can be released only if I sign the special consent below.

I HEARBY REQUEST AND AUTHORIZE THE FOLLOWING EXCHANGE OF INFORMATION BETWEEN:

Jeffrey S. Feldman, MD

340 Main Street, Suite 101

Melrose, MA 02176

Phone 781-662-4560

Fax: 781-662-4585

AND

Name: _____

Address: _____

_____

Phone: _____

Relationship to Patient: _____

I agree to allow my doctor, Dr. Jeffrey S. Feldman, to discuss my medical care with the person I designate in order to coordinate my medical care. I allow conversations about my general health care and only the following checked off :

My signature below allows conversation/discussion relating to testing, diagnosis and treatment for:

- ❑ Mental Health/Psychiatric Disorders
- ❑ Drug, Alcohol Use/Abuse/Treatment
- ❑ Sexual Orientation/Sexual Activity
- ❑ Birth Control/Pregnancy
- ❑ HIV/AIDS Virus/Sexually Transmitted Diseases

Date:_____ **Signature:_____**

Phone:_____ **Email: _____**