Dr. Raymond M. Fuchs, Ph.D.
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Disclosure Authorization

I am completing this form to allow the use and sharing of protected health information about:

Patient name: ____ Date of Birth: ___________

I authorize **Dr. Raymond M. Fuchs, Ph.D.** to release documents listed below:

To Name of Facility or persons:____

Above Persons Contact Ph#:______________________________Fax#_________________________

Above Persons Address: ____

City__________________State_______________Zip____________

Dates of care included: From _______________ to _____________________

The information will be used/disclosed for the following purposes:
____
____

I understand and agree that this Authorization will be valid:

valid from (date):___________________expire on (date):_________________________________

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one. I understand that I may inspect and review a copy of the health information described in this authorization. There may be a cost for this copy or other services. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations. I affirm that anything in this form that was not clear to me has been explained adequately for my understanding. I have also received a copy of this completed form.

____
Printed name of Patient

____ _______________________
Patient Signature Date