Hillarie R. Budoff, M.D.
983 Park Avenue
New York, NY 10028
(646) 391-6499

Release of Information

I hereby authorize: ☐ Hillarie R. Budoff, M.D.

To: ☐ Release information to: Name: _____
☐ Obtain information from: Address: _____
☐ Exchange information with: Name: _____
_____
Telephone: _____

The information requested or authorized for release or exchange pertains to:

- ☐ Mental Health
- ☐ Education
- ☐ HIV/AIDS
- ☐ Sexually transmitted diseases
- ☐ Drug or alcohol abuse

This authorization is valid for 90 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date