AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Specific information to be released:

[] Verbal/Telephone Updates
[] Discharge Summary/Summary of Treatment
[] Laboratory/Radiology/EEG/ Reports
[] Consultation(s)
[] Other_____
_____
_____
_____

[] I hereby authorize the following person(s) and/or organization(s) to release the above information to:

David L. Nathan, M.D.
601 Ewing Street, Suite C-10
Princeton, New Jersey 08540
Phone: (609) 688-0400
Fax: (609) 688-0401

AND/OR

[] I hereby authorize Dr. Nathan to release the above information to the following person(s) and/or organization(s):

Person(s) and/or Organization(s)

_____ _____
_____ _____
_____ _____

_____ _____
_____ _____
_____ _____

I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue until termination of treatment unless otherwise specified: _____. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

X_____ _____
Signature of Patient (if 18 or older);
Or Parent (if patient under 18);
Or Legal Guardian; or Health Care Agent

Signature of Witness

X_____ **X**__/__/__ _____ __/__/__
Printed Name of Patient or Authorized Person — Date — Printed Name of Witness (if other than Dr. Nathan) — Date

X__/__/__
Patient's Date of Birth

_____
Title of Authorized Person (if applicable)