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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____
DOB: _____
Address: _____

I authorize Dr. James Fraiman to obtain and/or provide medial history and other related information regarding my treatment from/to the following people:

Name:	Telephone:

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke this authorization at any time.

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.

Signature: _____

Printed Name: _____

Date: _____

NOTICE OF CONFIDENTIALITY:

It is understood and agreed to by the recipient of the document or communications requested above that this is privileged information within the doctor-patient relationship, and is confidential material by law. Further disclosure or release of the documents or their contents by the recipient or any other party is not authorized without the above patient's written consent.