

Enrique Ergas, MD & Thomas Youm, MD

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HIPAA AUTHORIZATION FORM

Name _____ Date of Birth _____

Address _____

I hereby authorize use of protected health information about me as described below.

1. The following person/class of person/facility is authorized to use or disclose information about me: **Enrique Ergas, MD/ Thomas Youm, MD, 1056 5th Avenue, NY, NY 10028**

2. The following person may receive disclosure of protected health information about me:

Name & Address: _____

3. The specific information that should be disclosed : _____(check) All information

Or specify: _____

Unless you sign here, no information about alcohol, substance abuse, HIV/AIDS, or mental health will be disclosed: Yes, disclose this information _____

No, do not disclose _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulation.

5. I may revoke this authorization by notifying **Enrique Ergas, MD/ Thomas Youm, MD**, in writing of my desire to revoke it. However, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on _____. OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me.

Signature: _____

Date: _____

Or, if applicable:

Signature Guardian _____

Date: _____