NORANA CAIVANO, MD
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AUTHORIZATION TO USE OR DISCLOSE MEDICAL OR MENTAL HEALTH INFORMATION

Name of Patient (list any other names used) Date of Birth

Address Telephone Number

I hereby authorize:

Name of Disclosing Party

Address

City State Zip

Telephone

To disclose to:

Name of Recipient

Address

City State Zip

Telephone

SPECIFY RECORDS: Check the box to specify which type of information is to be disclosed.

- ☐ MEDICAL INFORMATION
- ☐ PSYCHIATRIC INFORMATION
- ☐ DRUG / ALCOHOL INFORMATION
- ☐ BILLING PURPOSES (if someone other than yourself will be paying for your care)

REASON FOR AUTHORIZATION:

- ☐ At the request of the individual
- ☐ For ongoing clinical care
- ☐ For legal purposes (fees may be involved)
- ☐ Other: _____

DURATION: This authorization is effective immediately and will remain in effect for one year from the date of my signature unless a different date is written here:_____

MY RIGHTS: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Norana Caivano, MD based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, please write a letter to the office stating so. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

You have a right to a copy of this authorization upon request.

Patient (or legally authorized individual) signature Date

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)