I, _____, hereby authorize Bernadette Barron, NPP

(Patient Name) (Nurse Practitioner Psychiatry)

To disclose information and records obtained in the course of my diagnosis and treatment, and to receive information about my diagnosis and treatment for the following purpose: to increase understanding of my previous history, diagnosis, and treatment; to coordinate care on an ongoing basis with other providers that are also treating me; or to discuss my care with friends or family that my provide support.

Information is to be disclosed to:

1. Dr. Amy Koreen, MD, Huntington NY
Name of individual/organization, phone number, address

2._____
Name of individual/organization, phone number, address

3._____
Name of individual/organization, phone number, address

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by Bernadette Barron, NPP to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and signing of this authorization and Bernadette Barron, NPP shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although application state laws may protect such information. This authorization is effective immediately and remains in effect for 1 years unless explicitly revoked in writing.

Signature: _____ Date: _____

Print name: _____