

below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

The address of the Practice's Administrative Director is 150 E 32nd Street, NY, NY 10016, and I may contact the Administrative Director by telephone at 212-545-5400

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Signature of Patient

Date

If the patient is a minor or is otherwise unable to sign this Authorization, please complete the information below:

Signature of authorized
Personal Representative

Description of
Authority

Date