MARC S. KITROSSER DPM PA
AUTHORIZATION TO DISCLOSE INFORMATION

I _____, understand that my information, which is retained by Marc S. Kitrosser DPM, PA, may not be disclosed to another person without my express written authority. I hereby give authority to Marc S. Kitrosser DPM to disclose any and all information regarding:

Name (Print)

:_____

Date of Birth

_____

To the following individual:

_____ _____

_____

*Name *Telephone Number * Fax Number

This authorization expires one year from the date signed below. I understand that upon this expiration date, Dr Kitrosser or his staff will no longer provide my information to the person stated above, and that if I wish for this person to continue to receive information, I must execute another authorization. I understand that if the above-named person is not a health care provider or part of a health plan covered by federal privacy regulations, my **health** information may be re-disclosed by the person I have named above and will no longer be protected by these regulations. However, the person named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that if I refuse to sign this form, the Office of Marc S. Kitrosser, DPM PA will not disclose my information to the person named above. I understand I may revoke this authorization at any time, in writing, except to the extent the Office of Dr. Kitrosser has taken action in reliance on this authorization.

The written request to revoke this authorization must be provided to the Office of Marc S. Kitrosser. The revocation will be effective on the date that the Office of Marc S. Kitrosser has received this written request.

Substance Abuse Information Only

: Further, I understand that if I am authorizing the Office of Marc S. Kitrosser DPM PA to disclose information about **substance abuse**, I must state the purpose of the disclosure. My purpose in allowing the Department to disclose this information is as follows:

_____

_____

_____.

*Signature (or mark) of Individual, Parent of Minor Child, Legal Guardian or Attorney

:

_____

*Date of Signature

: ***Telephone Number:**

_____ _____

Name of Parent of Minor Child, Legal Guardian or Attorney:

_____

Copy of Valid Appointment of Guardianship or Power of Attorney must be attached.

If a mark is provided in place of a signature, above, the mark must be witnessed:

Witness Signature (if applicable):_____

Witness Name/Title:_____