

***D. Victoria Martin, M.D.***

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**Authorization For The Release Of Information**

I hereby authorize  D. Victoria Martin, MD

\_\_\_\_\_  
(NAME OF PERSON OR ORGANIZATION)

\_\_\_\_\_  
(ADDRESS)

to release information from the medical records concerning:

\_\_\_\_\_  
(PATIENT NAME)

\_\_\_\_\_  
(DATE OF BIRTH)

to:  D. Victoria Martin, MD

\_\_\_\_\_  
(NAME OF PERSON OR ORGANIZATION)

\_\_\_\_\_  
(ADDRESS)

I understand that such disclosure will be made for the purpose of evaluation and/or continued treatment. If other, please specify purpose: \_\_\_\_\_

\_\_\_\_\_

Such disclosure will be limited to the following specific types of information:

- History
- Physical Examination
- Discharge Summary
- Other \_\_\_\_\_
- Psychological Testing
- Social History
- Laboratory Tests

\_\_\_\_\_

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon and in any event, shall expire six (6) months from the date of signature.

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(PATIENT SIGNATURE)

\_\_\_\_\_  
(WITNESS)

\_\_\_\_\_  
(PARENT OR LEGAL GUARDIAN)

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information, except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.