Louisa J. Steinberg, M.D., Ph.D.

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Authorization for Release of Information

Patient's name: ____

I hereby authorize Dr. Louisa J. Steinberg, M.D., Ph.D., to contact and obtain and/or provide my medical history and other related information from/to the following people:

Name:	Telephone:
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

I understand that this correspondence may involve a conversation or a transfer of written material and that I have the right to revoke the above authorization at any time.

Signature: _______________________________

Printed Name: ____________________________

Date: ____________________________________

NOTICE OF CONFIDENTIALITY

It is understood and agreed to by the recipient of the document or communications requested above that this is privileged information within the doctor-patient relationship, and is confidential material by law. Further disclosure or release of the documents or their contents by the recipient of any other party is not authorized without the above patient's written consent. Furthermore, it is understood that the patient may withdraw his/her consent to this release at any time.