AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient:

Name_____ **Date of Birth**_____

Address_____

Current Physician:

Name_____

Address_____

Phone_____**Fax**_____

Recipient: I authorize my health care information to be released to the following physician:

Robert Cywes, M.D., PhD
2865 PGA Blvd.
Palm Beach Gardens, FL 33410
(561) 627-4107 phone
(561) 627-5069 fax

Information to be disclosed: I authorize the release of the following health information:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

- Only the following records or types of health information: **all progress notes showing patient's height, weight, and BMI or a list of dates with the information requested for the past 3 years**.

_____ _____ _____
Signature Date Signature of Witness

By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the physician named above.

Term: **I understand that this Authorization will remain in effect until the following date(s)** _____**or for 6 months from the date signed.**