

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**Explanation – Read before signing the authorization**

*This authorization gives permission for Brian R. Buinewicz, M.D. to disclose health information about you.*

*You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit your revocation in writing to our privacy officer at the address listed below.*

*Health information disclosed pursuant to this authorization may be re-disclosed by the recipient if the recipient is not subject to the privacy rule promulgated by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”) and the re-disclosure is not otherwise prohibited by law.*

**Current contact information for our Privacy Officer:**

*Brian R. Buinewicz, M.D.  
Attn: MaryAnn Roth  
3655 Route 202  
Ste. 225  
Doylestown, PA 18902  
215-230-4013  
FAX: 215-230-4143*

**Authorization**

I have read and understand the above Explanation. I request and authorize Brian R. Buinewicz, M.D. to disclose health information pertaining to \_ (*patient name*) in accordance with the following:

- 1. Covered health information – Provide specific description (for example, medical records for services rendered by Brian R. Buinewicz, M.D. from March 1998 to December 2001 or July lab reports):*

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2. *Specific persons or class of persons to whom the covered information can be disclosed:*

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*\*Include mailing address if a copy is to be mailed.*

3. *Expiration of authorization – Provide date or event (for example, July 31, 2002 or when this authorization is revoked):*

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*Signature of patient  
(or personal representative for the patient)*

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*Date*

*Personal Representative Information (if applicable)*

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*Name of personal representative*

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*Relationship to patient  
(or other authority to serve as personal representative)*