



*Andrew E. Leifer, M.D., P.C.*  
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**Authorization For Release of Information**

TO (Person Sharing / Receiving Information with Dr. Leifer):

Name of Provider/Agency/Family Member: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Andrew E. Leifer, M.D., P.C., to share and receive information regarding my health care with \_\_\_\_\_ for purposes of continuity of care and treatment. I understand this may include information regarding my psychiatric history, medical records and treatment, and/or substance use. This authorization to disclose information is subject to revocation at any time when such revocation is provided by the patient in writing, except to the extent that Dr. Leifer and/or the named provider/agency has already acted in reliance on it.

Thank you,

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

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This authorization for release of information expires on (circle one):

Indefinite release.

Or

Specific date: \_\_\_\_\_