

**The Institute for Healthy Aging**  
Attn: Mark A. Rosenberg, M.D., FACEP  
101 NW 1<sup>st</sup> Avenue, Delray Beach, FL 33444

## Authorization to Use or Disclose My Health Information

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

### I. My Authorization

**You may use or disclose the following health care information (check all that apply):**

- All my health information maintained by the above-named practice  
(Circle "include" or "exclude" for each of the following)
- Include or Exclude My health information related to drug abuse
- Include or Exclude My health information related to alcohol abuse
- Include or Exclude My health information related to HIV/AIDS
- Include or Exclude My health information related to psychological or psychiatric conditions, including psychotherapy notes
- My health information relating to the following treatment or condition: \_\_\_\_\_
- My health information for the date(s): \_\_\_\_\_
- Other: \_\_\_\_\_

**You may disclose this health information to:**

Name (or title) and organization:

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

**Reason(s) for this authorization (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> At my request                           | <input type="checkbox"/> Check here only when <b>The Institute for Healthy Aging</b> requests the authorization for marketing purposes                                   |
| <input type="checkbox"/> Other (specify) _____<br>_____<br>_____ | <input type="checkbox"/> Check here only when <b>The Institute for Healthy Aging</b> will get something of value for providing health information for marketing purposes |

**This authorization ends:**  on (date) \_\_\_\_\_

when the following event occurs \_\_\_\_\_

