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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I, _____, hereby authorize **Dr. Lesley Castellini, LLC,** to disclose certain specific health information from the records of the above-named patient to the following individual or organization: _____

_____ (name, address of recipient) for continuity of care.

I understand I may revoke this authorization at any time by giving in writing. I further understand the revocation will not apply to information that has already been released in response to this authorization. I understand that my authorization to disclose the health information here under is voluntary and I can refuse to sign this authorization. I need not sign this authorization form in order to receive any treatment. I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be re-disclosed by the person or agency that receives it

By signing, I acknowledge that I understand the above,

_____ _____
Patient's Signature Date