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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_________________________________Date of Birth:____________________

I request and authorize (include name, phone and fax if available) ________________________

____

to release healthcare information of the patient named above to: name, address, & title of person/facility/organization to which this disclosure is to be made: *Diana E. Moga, MD,PhD, 575 West End Ave, GRB-B,, New York, NY 10024 T (212)362-0481 F (866)586-5679.*

This request and authorization applies to:

[ ] Healthcare information relating to the following treatment, dates, condition, studies:____

____

[ ] All healthcare information

The purpose of this disclosure is: ____

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Patient Signature: _________________________________Date Signed: __________________