Brian Buggie, MD ● 445 West 23rd Street, Suite 1EE ● NYC 10011 ● 646-580-8839

Consent to Release Protected Healthcare Information

Patient's Name: _____

I authorize Dr. Brian Buggie and the following persons/agencies listed below to disclose and share confidential information about me. This confidential information includes, but is not limited to: my alcohol and drug use history, psychological/psychiatric history, medical history; family history, legal and financial status, treatment history, results of diagnostic tests, urine tests, and clinical progress reports; current or planned treatment I may receive; all aspects of my treatment and clinical progress; and, all other information deemed important by Dr. Buggie to assist with my treatment and/or other personal or business matters including but not limited to insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc.

I authorize release of this information to and from the following persons, organizations, and/or agencies:

Your Initials: _____

Your psychiatrist, psychologist, or other therapist (specify):

Your Initials: _____

Your medical physician (specify):

Your Initials: _____

Family members: (specify):

Your Initials: _____

Your attorney (specify):

Your Initials: _____

Others (specify):

I acknowledge that this consent can be revoked by me in writing and that I can do so at any time for any reason except to the extent that: (a) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (b) disclosure has already occurred; and, (c) any pending action already taken and/or in progress that relies on this disclosure.

Patient's signature: _____ Date signed: _____

Fax Results to 646-572-9137