Xenia Protopopescu MD PhD
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tel 646-363-6590

**Authorization for Release of Information**

I give Xenia Protopopescu MD permission to contact and get history and information from the following people/institutions:

Name: Telephone:

_____ _____

_____ _____

_____ _____

_____ _____

I hereby authorize Xenia Protopopescu MD to:

▫ Release information to: ▫ Obtain information from: ▫ Exchange information with:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

The information requested or authorized for release or exchange pertains to:

▫ Mental Health ▫ Education ▫ HIV/AIDS
▫ Sexually transmitted diseases ▫ Drug or alcohol abuse

This authorization is valid for 90 days from the date below or _____, (not to exceed 1 year). I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Signature: _____ Date: _____

Printed Name: _____ DOB: _____

Relationship to Patient: _____ (self, parent, legal guardian)