Candida Fink MD

4 Stanton Circle
New Rochelle NY 10804
Phone 877-534-1090 Fax 914-560-2106

CONSENT TO RELEASE INFORMATION

DATE: ______________________

I hereby give Dr. Fink permission to communicate with the following individual/organization to assist in continuity/coordination of care for:

Myself OR **My Child** (circle one)

Patient Name: ____

Date of Birth: ____

Individual/Organization Name: ____________________________________

Address: ____

City: ______________________ State: _____________ Zip: ___________

Telephone: _____________________ Fax: ___________________________

Communication methods may include voice/telephone, fax, secure email, or other electronic formats including CD/DVDs with pdf files, flash drives, or secure web-based portals. You may request or restrict specific methods of communication. Content may include medical and educational records as well as professional opinions/discussions of diagnosis and care. Please indicate below any requests or restrictions to methods and content of communications

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THIS AGREEMENT WILL REMAIN IN EFFECT WHILE PATIENT IS UNDER DR. FINK'S CARE , UNLESS IT IS RESCINDED BY PATIENT/REPRESENTATIVE. IN ALL OTHER CIRCUMSTANCES THE AGREEMENT WILL EXPIRE ONE YEAR FROM THE DATE INDICATED ABOVE

____
Patient or Patient Representative Printed Name/Relationship

____
Patient or Patient Representative Signature and Date Signed