## AUTHORIZATION TO PERMIT INTERVIEW OF TREATING PHYSICIAN BY DEFENSE COUNSEL

| TO:Physi   |   |  |
|--|---|--|
| Physi  | cian's name and address   |  |
| You are hereby authorized to discuss certain medical o   | condition(s) involving:   | with   |
|  | Patient's name  |  |
| Defense Attorney's N   | lame and Address  | who is an attorney   |
| representing   | in a  |  |
| representing Defendant's name  |   | Type of Lawsuit  |
| brought by agair   | ist   |  |
| Plaintiff(s) Name  | Defenda   |  |
| The lawsuit is currently pending and is at   |   |  |
| The lawsuit is currently pending and is at   | Stage   | of Proceeding  |
| 1. NOTHING CONTAINED HEREIN AUTHORIZE<br>THAN THE ABOVE-STATED MEDICAL CONDI   |   | NG ABOUT THIS PATIENT OTHER  |
| 2. THE PURPOSE OF THIS INTERVIEW IS T<br>LAWSUIT BROUGHT BY THIS PATIENT. TH<br>PATIENT.   | O ASSIST THE DEFENDAN<br>IIS AUTHORIZATION IS NO  | NT(S) IN THE DEFENSE OF THIS<br>DT AT THE REQUEST OF YOUR  |
| 3. YOUR WILLINGNESS TO PARTICIPATE IN 1<br>TO DECLINE THE REQUEST FOR SAID INTER   |   | LY VOLUNTARY. YOU ARE FREE   |
| 4. You are permitted to disclose information relating to A psychotherapy notes, and <b>CONFIDENTIAL HIV RELA</b> ( <i>Indicate by Initialing</i> ): Alcohol/Drug Treatmen  | TED INFORMATION only if spec  | ifically initialed below:  |
| 5. If I am authorizing the release of HIV-related, alcoho<br>is prohibited from redisclosing such information without<br>understand that I have the right to request a list of people<br>If I experience discrimination because of the release of<br>Division of Human Rights at (212) 480-2493 or the N<br>agencies are responsible for protecting my rights. | my authorization unless permitte<br>who may receive or use my HIV-r<br>disclosure of HIV-related inform | ed to do so under federal or state law. I<br>related information without authorization.<br>ation, I may contact the New York State |
| 6. I have the right to revoke this authorization at any to revoke this authorization except to the extent that action  |   |  |
| 7. I understand that signing this authorization is volume<br>benefits will not be conditioned upon my authorization of   |   | rollment in a health plan, or eligibility for  |
| 8. Information disclosed under this authorization might redisclosure may no longer be protected by federal or s  |   | xcept as noted in Item 5 above), and this  |

| 9. If not the patient, name of person signing form: |  |
|---|--|
|   |  |

10. Authority to sign on behalf of patient:

| 11.Date this authorization will e | expire: |
|-----------------------------------|---------|
|-----------------------------------|---------|

Signature

Date