Anna Filova, MD

Phone: 1(646)734-6770
Fax: 1(646)328-1178

1150 5th Ave , 1C
New York, New York 10128

275 North Street
Harrison, New York 10528

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____

DOB: _____/_____/_____ I

I authorize my provider Dr. Filova to discuss my medical information with the following:

Name: _____

Address: _____

City/State: _____ Zip: _____

Telephone: (_____)_____

Fax: (_____)_____

This request for release of information applies to (please select one):

___ Healthcare information pertaining to above patient's psychiatric care, diagnosis and medication INCLUDING addiction related treatment

___ Healthcare information pertaining to above patient's psychiatric care, diagnosis and medication EXCLUDING addiction related treatment

___Specific information: _____

Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq., includes herpes, HSV, HPV, genital warts, condyloma, non-specific urethritis, canchroid, lyphogranuloma venerium, chlamydia, syphilis, HIV, AIDS and gonorrhea.

I **__ do __do not** authorize the release of my STD related information (STD results, HIV/AIDS status or test results), to the person(s) listed above. I understand the person(s) above will be notified that I must give specific written permission before this type of health information is released.

Patient/Guardian signature: _____ Date: _____

This authorization expires when treatment is terminated and may be revoked by the patient at any time.