AUTHORIZATION TO PERMIT INTERVIEW OF TREATING PHYSICIAN BY DEFENSE COUNSEL

TO: _____
Physician's name and address

You are hereby authorized to discuss certain medical condition(s) involving:

_____ with
Patient's name

_____ who is an attorney
Defense Attorney's Name and Address

representing _____ in a _____
Defendant's name Type of Lawsuit

brought by _____ against _____
Plaintiff(s) Name Defendant(s)

The lawsuit is currently pending and is at _____
Stage of Proceeding

YOU ARE PERMITTED TO DISCUSS ONLY THE FOLLOWING MEDICAL CONDITIONS WHICH ARE THE SUBJECT MATTER OF THE AFOREMENTIONED LAWSUIT: _____

_____

1. NOTHING CONTAINED HEREIN AUTHORIZES YOU TO DISCUSS ANYTHING ABOUT THIS PATIENT OTHER THAN THE ABOVE-STATED MEDICAL CONDITIONS.

2. THE PURPOSE OF THIS INTERVIEW IS TO ASSIST THE DEFENDANT(S) IN THE DEFENSE OF THIS LAWSUIT BROUGHT BY THIS PATIENT. THIS AUTHORIZATION IS NOT AT THE REQUEST OF YOUR PATIENT.

3. YOUR WILLINGNESS TO PARTICIPATE IN THIS INTERVIEW IS ENTIRELY VOLUNTARY. YOU ARE FREE TO DECLINE THE REQUEST FOR SAID INTERVIEW.

4. You are permitted to disclose information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if specifically initialed below:
(*Indicate by Initialing*): _____ **Alcohol/Drug Treatment;** _____ **Mental Health Information;** ____ **HIV-Related Information**

5. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

6. I have the right to revoke this authorization at any time by writing to the health care provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

7. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

8. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in Item 5 above), and this redisclosure may no longer be protected by federal or state law.

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

10. Authority to sign on behalf of patient: _____

11.Date this authorization will expire: _____

_____ _____
Signature Date