STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed

The information covered by this authorization includes:

OFFICE NOTES & LAB RESULTS

Persons Authorized to Use or Disclose information

Information listed above will be used or disclosed by:

LESTER KRITZER, M.D., F.A.C.E.

Name of person or organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Name of person or organization

Name of person or organization

Expiration Date of Authorization

This authorization is effective through----/-----/-----/ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **LESTER S. KRITZER, M.D.** You should contact the Compliance Officer to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature **Date**