

ANKUR U. SARAIYA, M.D.
200 WEST 70TH STREET · SUITE 16R · NEW YORK, NY 10023
212-721-6823

DATE: _____

I, _____, authorize the below-named individuals and/or institutions to release any and all information related to my treatment and medical/social/psychiatric history to Dr. Ankur Saraiya.

I furthermore authorize Dr. Saraiya to discuss my treatment with the below-named parties for the purpose of facilitating my treatment, understanding that Dr. Saraiya will only discuss those details of my treatment necessary to my care.

(Please list below the names of individual providers covered by this release with contact information)

_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may revoke this authorization by delivering written, signed notice to Dr. Saraiya by hand or certified mail.

Client signature

(please print name)