Patient Disclosure and Authorization of Information to Other Physicians

Some of Dr. Leder's patients may want her to advise another of their physicians of her suggested treatment approach. Upon patient request and authorization, Dr. Leder will be pleased to communicate her protocol with any other doctor(s). Please set forth below the names, addresses, telephone numbers, and fax numbers of any and all physicians with whom you wish Dr. Leder to communicate on your behalf with respect to her suggested treatment approach, or indicate below that this is not your wish.

Doctors Name:_____
Address: _____
Telephone and Fax Number:_____
Condition(s) for which they treat you:_____
_____

Doctors Name:_____
Address: _____
Telephone and Fax Number:_____
Condition(s) for which they treat you:_____
_____

Doctors Name:_____
Address: _____
Telephone and Fax Number:_____
Condition(s) for which they treat you:_____
_____

Doctors Name:_____
Address: _____
Telephone and Fax Number:_____
Condition(s) for which they treat you:_____
_____

( ) I do not request/authorize Dr. Leder to discuss her suggested treatment(s) with any other physician(s).

_____ _____
Patient Signature (Guardian) Date

_____ _____
Patient Name Witness Signature