VIVIAN CHERN SHNAIDMAN, M.D.
Diplomate, American Board of Psychiatry and Neurology and Forensic Psychiatry
10 Vreeland Drive Suite 103, Skillman, NJ 08558

At the request of the individual, I, ___________________, hereby authorize the release and re-disclosure, via paper, email, fax, or verbal/telephone communication, of any and

□ all medical, psychiatric, and psychological records;

□ any drug and alcohol abuse treatment information; and

□ any HIV/AIDS information kept by:

TO: Vivian Chern Shnaidman M.D.
10 Vreeland Drive Suite # 103
Skillman, NJ 08558
Phone: 609-910-1715
Fax: 609-964-1700

From:

____
____
____
____
____

Phone: ___________________________

Fax: ________________________

Name (Print)	Signature	Date
Witness Name (Print)	Signature	Date
Parent or Legal Guardian (Print)	Signature	Date

Authorization is subject to revocation at any time by the patient unless the provider has already relied upon it. Authorization will expire in accordance with our record retention policy. For activities covered by HIPAA, I do not condition treatment, payment, enrollment, or eligibility for benefits on this authorization.