

If my treatment is related to my participation in a research study, I understand that the Practice may refuse to treat me if I do not sign this Authorization,” and (2) the patient would be permitted to designate an expiration date/event of “none.”

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Practice's Office Manager at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

The address of the Practice’s Office Manager is 935 Northern Boulevard, Suite 300, Great Neck, NY 11021, and I may contact the Office Manager by telephone at 516 466-5437 or by email at manager@MDS4kids.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Signature of Patient

Date

If the patient is a minor or is otherwise unable to sign this Authorization, please complete the information below:

Signature of authorized
Personal Representative

Description of
Authority

Date

**[If the Practice has requested this Authorization,
provide a copy of the signed Authorization to the patient.]**