

Authorization for Disclosure of Patient Information



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Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

I hereby authorize _____

(Facility/Provider Name and Location)

to release information from the medical record of _____

(Patient Name)

The following information may be released:

Release for the following purpose:

- All pertinent records
- Records from the last _____ year(s), including progress notes, immunizations, labs, x-ray reports & consult notes
- Lab reports – date(s)
- X-Ray report(s)
- Progress Notes – date(s)
 - Other (please specify) _____

- Legal
- Insurance
- Patient Request
- New Pediatrician
- Other (please specify) _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby *specifically* authorize the release of data and information relating to: (check any that apply)

- HIV/AIDS related testing
- Mental Health
- Chemical Dependency (Drug/Alcohol)

This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

Telephone Number: _____

Fax Number: _____

This authorization will be valid for 180 days from the date it is signed or until _____, whichever is shorter. This authorization may be received at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

Signature of Patient or Legal Guardian
(Parent/Legal Guardian must sign if patient is a minor)

Date: _____

Relationship to patient, if not the patient

For Office Use Only:

Copied by: _____ Date: _____

To be sent/mailed

To be picked up

Date sent/mailed: _____

Approved for release by M.D. _____