



# Ronald P. Fogel MD, FACP, FACG

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## AUTHORIZATION TO RELEASE/REQUEST MEDICAL RECORDS INFORMATION

TO: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize the above listed entity to  **release**  **receive** my protected health information.

I hereby authorize use or disclosure of the named individual's Protected Health Information (PHI) as described below:

patient name	date of birth	Social Security number
address (street, city, state, zip code)		telephone number
treatment dates:	purpose of request:	

The following information is to be disclosed:

*(Please check one box for each item requested – if "complete record" is indicated, no further boxes need to be checked off)*

yes	no	yes	no	yes	no
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	.....COMPLETE RECORD		.....cardiac		..... x-ray reports
<input type="checkbox"/>	.....physician/office notes	<input type="checkbox"/>	.....tests	<input type="checkbox"/>	.....history & physical
<input type="checkbox"/>	.....lab results	<input type="checkbox"/>	.....other _____		

**sensitive information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse unless indicated below.

I do not authorize the release of records regarding HIV infection, AIDS related Complex, and/or serious communicable diseases.

I do not authorize the release of records regarding drug/alcohol abuse

**redisclosure:** I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

**right to revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

**Other rights:**

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event or condition:  
*(If I do not specify an expiration date, event or condition, this authorization will expire in one year).*

Signature of patient or legal representative:	Date	Witness Signature:	Date
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If signed by legal representative, relationship to patient: