Authorization To Release Or Obtain Protected Health Information

Dr. David Feldman
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P. 212-366-0599 F. 888-816-5272

I authorize the office of Dr. David Feldman to either obtain or disclose my protected health information as specified below.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that revocation will not apply to the information that has already been released in response to this authorization.

This authorization will expire on _____. If no expiration date is specified, this authorization will expire one year from the date signed.

Patient Name: _____ **Date of Birth:** _____

Telephone #: _____ **Social Security Number:** _____

Patient Address: _____

_____

Name & Address of person to whom information will be sent:

_____

_____

<u>Information To Be Disclosed</u> (Please be as specific as possible)

Medical record from (insert date) _____ **to** (insert date) _____

Include:

- ❏ Operative / Procedure Report(s)
- ❏ Consultation Letters
- ❏ Progress Notes
- ❏ Laboratory
- ❏ Radiology
- ❏ Pathology
- ❏ Other _____

Include / Consent:

- ❏ Alcohol / Drug Treatment
- ❏ Mental Health Information
- ❏ HIV-Related Information

Electronic Delivery (provide valid email address) _____

I understand there is a $0.75/page fee (as per NY state law) in connection with the processing of my medical record request.

Signature: _____

Patient or Authorized Representative: _____ **Date:** _____