RELEASE OF INFORMATION

Name: _____ Date of Birth: DD MM YY

By signing this form, I authorize (name and address of physician/clinic/entitiy)

- ☐ Yasmin Maldonado-Stitt, MD
- ☐ Other: _____

to release confidential health information about me, by releasing a copy of my medical records, to the physician/clinic/entity below (name, address, and fax number)

_____

The health information that relates to the dates of service from _____ to _____ may be released and may include (mark below):

- ☐ Entire medical record
- ☐ Chart Notes
- ☐ Lab reports
- ☐ Radiology reports
- ☐ Treatment records
- ☐ Billing records
- ☐ Insurance records
- ☐ Medication records
- ☐ Other (specify below)

_____

For the purpose of:

_____

- I understand that unless revoked in writing, this authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- Unless specifically excluded below, this authorization includes release of specially protected information including referral, diagnosis and treatment information related to my health care.
- (Please circle all that apply to EXCLUDE the information from authorization and disclosure):

Substance Abuse Mental Health Conditions Sexually Transmitted Diseases HIV/AIDS

- I understand once my health care information is released, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.
- I understand release of my records may take up to 30 days.
- I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).

_____ Printed Name

_____ Signature

_____ Date

_____ Relationship to Patient