Rockland Endocrine & Diabetes Svcs.
Authorization to Release Medical Records

Name of Patient _____ **Date** _____

Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

INFORMATION TO BE RELEASED OR ACCESSED:
PLEASE CIRCLE ALL THAT APPLY

History & Physical Consultation Report Emergency Room Record

Operative Reports Discharge/Death Summary Face Sheet

Lab/Path Reports X-Ray Reports/Images Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP) Fax Number

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number Fax Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ **Signature:** _____/_____

Patient or Legally Authorized Representative / Relationship to patient