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Authorization for Disclosure of Medical Information

To: ( ) Dr. Reilly **From:** ( ) Dr. Reilly

Patient Name: _____ DOB: _____

Street Address: _____

City, State, Zip code: _____

Phone Number: _____

I Authorize information Release: To: ( ) From: ( )

Name of Physician/Third Party: _____

Phone Number: _____ Fax Number: _____

Street Address: _____

City, State, Zip code: _____

I authorize and request disclosure of:

( ) Office Visit Chart Notes

( ) Laboratory/Diagnostic Reports/Pathology

( ) Medication and Therapy

( ) Imaging Results

( ) All Medical Records From the Past ____ Years

( ) Other: _____

By signing this form, you are authorizing the use of disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information. You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire in 180 days from the date of signing. You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. With the exception of obtaining information in connection with eligibility or enrollment in a health plan.

Patient/Legal Guardian Signature: _____ Date: _____

Printed Name: _____