Robert H. Strashun, M.D., F.A.A.P

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AUTHORIZATION FOR RELEASE OF / TO OBTAIN MEDICAL RECORDS

Patient Name:____
Last First M.I.

Date of Birth:____________________ Social Security #:_____________________ Phone #:(___)______________

Address:______________________________________ ____________________ ________ _______________
Street City State Zip Code

I hereby authorize Dr. Robert Strashun to: *(Please check one)*

☐ **RELEASE** the following medical records **TO**:	☐ **OBTAIN** the following medical records **FROM**:
Name of Provider or Agency:	Name of Provider or Agency:
Address:	Address:

❏ Complete Health Records
❏ Laboratory Tests
❏ X-Ray Reports
❏ History and Physical Exam

❏ Other ____

For the following purpose: ____

Under Federal Law, the following information will not be released unless checked:

❏ HIV/AIDS Infection ❏ Behavioral Health Care ❏ Treatment for Alcohol and/or Drug Abuse

Unless otherwise revoked, this authorization will expire 60 days from the date noted below. I may revoke this authorization in writing at any time. I understand that such revocation will not have any effect on the information already used or disclosed before receipt of my written notice of revocation. I understand I may choose to restrict or extend the expiration date. I may request to inspect or copy the information to be disclosed. I may refuse to sign this authorization. I understand that I am not required to sign the authorization to receive treatment. Once release of this information is made to the above named person/organization, my information may be subject to redisclosure by the recipient. This authorization shall be effective for all medical information and records generated until the expiration date, even if the information is generated after the date of signing this authorization.

I may be charged fees for the copying of such information if I am requesting information for myself or for a third party. Such fees will comply with state and federal laws.

I have read the above information and authorize disclosure of the identified information to the person/organization and for the purpose described herein. I understand that, by signing this document, I release and discharge the disclosing entity from any liability and will hold it harmless for any release made pursuant to the authorization.

Date:_______________ Patient's or Guardian's Signature: ______________________________________
(Or other person authorized by Law to act on behalf of the Patient)

Relationship to patient:_________________________________

Date:_______________ Witness Signature: ______________________________________