

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
- X-Ray Reports
- Laboratory Tests
- 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: _____