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AUTHORIZATION FOR RELEASE OF INFORMATION TO DR. ASSALITA'S OFFICE

RECORDS TO BE MAILED OR HAND DELIVERED, NOT FAXED NOR MAILED

NOTE: ***Generally recommended for patients seeking second opinions in our office and who have already had that other specialists care. Some offices may not require you to complete a form- or they have their own form. Call them to ask.***

Patients should complete sections I and III.
SECTION A: Must be completed for all authorizations

I hereby authorize _____ (insert name of Doctor or Practice) and/or his/her/its staff to disclose my individually identifiable health information as described below. I understand that this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I. Patient name:_____ **Date of Birth:** _____
Persons/Organizations receiving the information: (name, address, phone #) to be mailed to our address.

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Specific description of information to be used or disclosed (check any/all that apply/dates):

_____Second Opinion _____ Insurance has Changed _____ Transferring _____ Moving

Other _____

II. SECTION B: Must be completed only if a health plan or a health care provider has requested the authorization:

1. The health plan or health care provider must complete the following:
   a) What is the purpose of the use or disclosure: _____
   (no purpose needed if the request is made by the patient & patient does not wish to state the purpose)
   b) Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes____No_____
2. The patient or the patient's representative must read and initial the following statements
   a) I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
   Initials _____
   b) I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials _____

III. SECTION C: Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on _____(DD/MM/YYYY) Initials _____
2. I understand that I may revoke this authorization at any time by notifying _____(insert name of practice) in writing, but if I do, it won't have any affect on any actions taken before receipt of my revocation.
   Initials _____

_____ _____
signature of patient or patient's representative date

Printed Name of Patient's Representative (if applicable):_____

Relationship to the patient (if applicable):_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION