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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____Date of Birth_____

Address:_____Phone (____)_____

I hereby release Dante P. Gabriel M.D., S.C. from any legal responsibility or liability that may arise from the disclosure of the above named individual's health information.

The type and amount of information to be used or disclosed is as follows (include dates where appropriate)

Consultations Only
Labs Only (from (date)_____to (date)_____)
Radiology Only (from (date)_____to (date)_____)
Immunization Records and/or Growth Chart
Complete Record (this does not include
Other (please specify)_____

I understand that the information in my health record may not include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) unless specific consent is given. Information about behavioral or mental services, and treatment for alchohol and drug abuse are also withheld unless I (the patient) give specific consent for specific mental/behavioral health records . _____ (INTIALS)

I (the patient) consent to copy and include the following records:

Sexual related information/testing and results. _____ Patient Initials

Mental Health records. _____ Patient Initials

Substance abuse records. _____ Patient Initials

The purpose for the release of information at the request of individual or parent is:

Insurance
Legal Action
Personal Use
Behaivoral Health
New Provider *
Continuity of Care
Other (please specify)_____

***Please feel free to leave a comment regarding our practice here:

_____

Send Records To: (Name of facility or person) _____

_____

Address State Zip Code

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date:_____.

I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand disclosure of information carries with it the potential for an authorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules

X / /

Patient/Parent/Legal Guardian Signature **Specify Relationship to Patient** **Date**

A Prepayment of $15.00 per chart is required. All payments are payable to Dante P. Gabriel, MD, SC