Dr. Renata Silva Starr
Dr. Arielle Franco

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____ **S.S.** _____

(Check One) _____ **Obtain From** _____ **Release To**

Name: _____
Address: _____
Phone: _____
Fax: _____

For the purpose of:(Example: Continued Care, Transfer Care, PCP, or Personal Records)

_____

___Entire Medical Records	___Diagnostic Tests
___Prenatal Records	___Include Drug/Alcohol Treatment
___Radiology Reports & Images	___Include Behavioral/Mental Information
___Pathology Reports & Specimens	___Include HIV-related Information
___Lab Results	___All of the above with the exception of_____

Expiration Date: This authorization will expire twelve (12) months from the date which it was signed unless otherwise specified: _____ **(date of expiration)**

Redisclosure: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing this authorization form is voluntary. I realized that treatment, payment, enrollment in a health plan, or eligibility of benefits will not be conditioned upon my authorization of this disclosure.

Revocation: I understand I may revoke this authorization anytime by writing a letter and presenting my revocation to the medical records department. I understand that the revocation will not apply to information that has been already released in response to my authorization.

_____ _____
Patient or Authorized Representative **Date**

_____ _____
Print Name **Relationship with patient**