MEDICAL RECORDS RELEASE
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date:_____ **Patient Name:**_____

DOB:_____ **E-Mail:**_____

Address:_____

Cell Phone:_____ **Home Phone:**_____ **Work Phone:**_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:
1. I have the right to revoke this authorization at any time. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

Name and address of health provider or entity to release this information:

Hara J. Schwartz, MD
PO Box 66
Fishkill, NY 12524

Identify to whom and in what manner this information will be sent:

- o Send my records to me via secure E-Mail. E-Mail: _____
- o Send my records via **E-Mail** to my Primary Care Doctor or new Dermatologist.
  Name of Provider:_____ E-Mail:_____

Specific information to be released:

- o All records and reports
- o Other (specify):
- o Records and reports from dates _____ to _____

If not the patient, name of person signing form: **Authority to sign on behalf of patient:**

_____ _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form. I understand that this authorization is valid for one year from date signed.

Signature of Patient or Representative Authorized by Law:_____ Date:_____

NOTE: THIS AUTHORIZATION IS **NOT** INTENDED TO AUTHORIZE DISCLOSURE OF INFORMATION RELATING TO ALCOHOL AND DRUG ABUSE, MENTAL HEALTH TREATMENT, AND CONFIDENTIAL HIV RELATED INFORMATION