185 OCEAN AVENUE, 1A
BROOKLYN, NY 11225
FAX: 347-669-0016

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. *Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

I hereby authorize: ____

Physician/Healthcare Facility

To release information on:

____

Patient's Name Patient's DOB

regarding medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: Amanda Harris, MD - Urban Family Doctor, PLLC
185 Ocean Avenue, 1A
Brooklyn, NY 11225
Fax: 347-669-0016

The medical information/records will be used for: CONTINUITY OF CARE WITH PCP

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information:

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse ____ (initial)
Psychiatric/Mental Health ____ (initial)
Tests for Antibodies to HIV HIV Diagnosis/Treatment ____ (initial)
Genetic Information ____ (initial)

DURATION

This authorization shall be effective immediately and remain in effect until ________________________

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

______________________ Signature of patient	______________________ Relationship if other than patient or legal/personal representative
______________________ Patient's Name (PRINT)	______________________ Date
______________________ Witness name	______________________ Witness signature