STUART I. FINKEL, M.D.

920 Park Avenue
New York NY 10028

Tel: 212-737-9736
Fax: 212-737-5317

AUTHORIZATON FOR USE OR DISCLOSURE OF HEALTH INFORMATION RELEASE FORM

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Patient:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____

To release to: _____

_____
[Persons/organizations authorized to receive the information: Address, street, city, state, zip code]

A. The following information is to be released:
[ ] Entire record
[ ] Other (please specify needed information and dates(s) of service if known: _____

_____

B. I understand that, pursuant to NY State law, I will be charged a copying fee of $0.75 per page, plus a postage, if records are copied by Dr. Finkel's office. Different charges may apply by the Custodian of Records after Dr. Finkel's office closes.

PURPOSE

The purpose of the release of this information is:
[ ] Continuity of medical care
[ ] At the request of the patient
[ ] Other: (specify) _____

RESTRICTIONS

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Stuart I. Finkel MD, his employees, and the Records Custodian of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

SIGNATURE

Date: _____ Time: _____AM/PM

Print Name: _____

Signature: _____
(Circle one: patient / spouse / representative / financially responsible party)

STUART I. FINKEL, MD

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATON RELEASE FORM, P.2

If signed by someone other than the patient, state your legal relationship to the patient:

_____

_____

Witness: _____

_____