Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____

Date of Birth: _____ Medical Record #: _____

Address: _____

_____

Telephone #: _____ Cell #: _____

☐ I hereby authorize the following medical practice to disclose / release my Protected Health Information as requested on this authorization:

Andrew M Romanowsky, MD LLC

Information to be disclosed / released to:

_____

_____

_____

OR

☐ I hereby authorize _____ to disclose / release my Protected Health Information as requested on this authorization to:

Andrew M Romanowsky, MD LLC
33 Bartlett St Ste 206
Lowell, MA 01852-1317

Tel: 978-458-1293 / Fax: 978-458-6953

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1. **Specific information to be disclosed / released:**

   ☐ **Medical record** from this date _____to this date_____.

   ☐ Medical Summary (Medications / Histories / Immunizations)
   ☐ Consult / Office Notes
   ☐ Lab / Pathology Results
   ☐ Radiology Reports
   ☐ Other: _____
   ☐ Cardiology Studies
   ☐ Hospital Consults / Initial Visit
   ☐ Hospital Discharge Summary

   ☐ **Entire medical record**: including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, and records sent to you by other health care providers.

   ☐ **Financial record**: billing / insurance records from _____ to _____

Purpose of Release: _____

Example: New Primary Care Physician / New Cardiologist / Care Coordination with other Specialist / Personal Use

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Patient's Name: _____ DOB: _____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, the authorized parties will release such information about me if it exists.

   Do **NOT** release the following information:

   - ☐ HIV/AIDS
   - ☐ Genetic Information
   - ☐ Mental Health
   - ☐ Sexually Transmitted Diseases
   - ☐ Treatment for alcohol and/or drug abuse

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying the authorized parties. I understand that any previously disclosed information would not be subject to my revocation request.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here:

   _____

   _____

This form must be fully complete before signing.

_____ _____

Signature of Patient or Patient's Legal Representative | Date

_____ _____

Print Patient's Name | Date of Birth

_____ _____

Print Name of Legal Representative (if applicable) | Relationship to Patient

☐ *Please accept my facsimile signature as an original*