Authorization For Release of Health Information To Designated Party

Patient Name:_____

Physician Name: Mario G. Silvestri, DPM

Designated Party:_____ Designated Party: _____

Relationship to Patient:_____ Relationship to Patient: _____

Address :_____ Address: _____

Phone: _____ Phone: _____

The information will be used or disclosed for the following purposes:

_____ At the request of the individual _____ Other _____

This Authorization grants PERMISSION to the Designated Party (ies) named above to:

_____ have access to my medical record information

_____ have access to my billing and insurance information

_____ have access to any test results

_____ make or confirm appointments

_____ other, please specify_____

I authorize Mario G. Silvestri, DPM, PC to use and disclose my health information as described in this authorization.

The patient or the patient's representative must read and initial the following statement:

_____ I understand that this information will expire only when revoked by the patient.

I understand that I may revoke this authorization at any time by notifying in writing the above named Physician

I understand that this authorization is voluntary

I understand that once this information is released to the Designated Party (ies), the release information may no longer be protected by federal privacy regulations

I understand that my treatment cannot be conditioned on whether I sign this authorization

I have been offered a copy of this office's Notice of Privacy Practices

_____ _____

Signature of patient or patient's representative Date

(Form MUST be completed before signing or will not be valid)