Authorization to Release Medical Records

Patient Information

Name _____DOB _____

Information to Be Sent From:

Name of facility or provider _____

Address _____

Information to Be Sent to:

Name of designated recipient _____Dr. Ewa Gawlik _____E.G. Greenpoint Pediatrics_____

Address _____Email: ewagawlikmd14@gmail.com_____Fax: 718-349-9511_____

Information To Be Released:

[ ] The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
[X] All medical records
[ ] Specific information (please verify): _____

Purpose for Which the Disclosure Is Being Made:

[ ] Attorney [ ] Insurance [X] Doctor [ ] Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*Exclude the following information from the records released (please initial)

[ ] Drug/Alcohol abuse/treatment & diagnosis [ ] Sexually transmitted disease
[ ] HIV/AIDS diagnosis/treatment//testing [ ] Mental illness or psychiatric diagnoses/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature _____ Date_____
(Patient, guardian*, or Authorized representative)