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Authorization: Disclosure of Health Information

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: Last __________________ First ____________________

DOB: _________ Phone Number: _________________

I hereby authorize Dr. Trapani to discuss and exchange relevant records with:

____
(Name of Person or Organization Receiving Information)

____
Mailing Address City State Zip Code

The recipient may use the health information authorized on this form for the following purpose: ____
(Specify)

I may refuse to sign and my refusal will not affect my ability to obtain treatment.
The recipient may not lawfully further use of disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law.
This authorization shall become effective immediately and shall remain in effect until __________________ (If no date is given, authorization is valid for 6 months only from signature date)
I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that Dr. Trapani has already disclosed the information.
I understand that I have the right to receive a copy of this authorization.

Signature: ___________________________ Date: _________________

If signed by other than patient, indicate relationship: _____________________