Marina I. Peredo, M.D., P.C.

Authorization For Release of Information

Patient Name: (Last, First)	Date of Birth:
Patient Address:	

Disclose Information From:	To:
Address:	Address:
Phone:	
Fax:	

Description of information to be used/disclosed:

I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Marina I. Peredo, M.D., P.C. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my ability for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524)

I Certify that I authorize the use of my health information as set forth in this document.

I am aware that there is a fee of .75¢ per page for medical records and a fee of $1.00 per photo, due prior to release.

Patient or Personal Representative Signature: _____

Print Name: _____ Date: _____

If Personal Representative, Give Relationship to Patient: _____

I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

Witnessed by Signature: _____

Print Name: _____ Date: _____

OFFICE USE:

Date Payment Received: _____ **or** Payment Waived Per _____ Initial: _____

Date Records Sent: _____ Mailed Faxed (Circle One) Initial: _____