Medical Records Release and Authorization
For Use or Disclosure of Protected Health Information Please complete the following information

Patient Name: _____
Address: _____
Phone: _____ SSN: _____ Date of Birth: _____/_____/____

I authorize the custodian of records of: _____
to disclose/release the following information* (**Enter Name of physician or practice and Phone & Fax Number**)

Patient Chief Complaint For Records:_____
(Enter Qualifying Condition)

☐ All records ☐Laboratory/pathology records ☐ X-ray/radiology records ☐Abstract/Summary
☐Pharmacy/prescription records ☐ Office Notes – Diagnosis and Treatments Including Med List

These records are for services provided on the following date(s): Past 6-24 Months **If no records in time period, then for the last visit for chief complaint

My specific authorization is necessary to release information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse, and or HIV/AIDS status. I understand that I have the right to review any mental health information before release of such information. I authorize the release of potentially sensitive information.
☐ Mental Health (including anxiety and depression) ☐ Substance Abuse ☐ HIV/Aids

Reason for Request: ☐ Consultation ☐ Transfer of Care

Please send the records listed above to: George Moskowitz, MD
1318 42nd Street
Brooklyn, NY, 11219
Phone: (347) 762 -0830
Fax: (718) 972 -5404

This authorization shall expire 12 months from the date hereof unless an earlier date or event is stated here:_____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. A copy of this authorization is available on request.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to Sign
(parent, guardian, power of attorney for healthcare, executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the custodian of records listed above.