Dr Russell M Blatstein
(772) 225 – 3668 (772) 337 – 2920
1635 NE Jensen Beach Blvd 1226 SE Port St Lucie Blvd
Jensen Beach, FL 34957 Port St Lucie, FL 34952

Authorization For Release of Medical Information

_____ _____ _____
Patient full name Date of Birth Social Sec #

_____ _____
Address City, State, Zip Code

(_____)_____-_____ (_____)_____-_____
Home Phone # Alternate Phone #

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ Facility Phone: (_____)_____-_____

Facility Address:_____ Facility Fax: (_____)_____-_____

City State Zip:_____

Dates and Type of information to disclose:
The purpose of disclosure is:

- 2 years prior from last date seen
- Dates Other: _____
- Specific Information Requested: _____

The purpose of disclosure is:

- Change of Insurance or Physician
- Continuation of Care
- Referral
- Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I authorize my records to be released to: DR RM BLATSTEIN DPM

- **Please Mail Records**
- **Please Fax Records**

1635 NE JENSEN BEACH BLVD
JENSEN BEACH, FL 34957
PHONE (772) 225 – 3668
FAX (772) 334 – 4115

1226 SE PORT ST LUCIE BLVD
PORT SAINT LUCIE, FL 34952
PHONE (772) 337 – 2920
FAX (772) 337 – 1234

I, the undersigned, have read the above and authorized the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time to the extent that action has been taken in reliance upon it. I acknowledge, and hereby consent to such, that the released information may contain all of my private health information. I also understand that any disclosure is bound by Title 42 of the code of Federal regulations governing that re-disclosure of the information to a party other than the one designated above is forbidden without additional written authorization on my part. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information" This authorization expires 365 days from the below date, and covers only the treatment periods indicated above.

_____ _____ _____
Date **Signature of Patient or Legal Guardian** **Relationship to Patient**