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PLEASE MAIL RECORDS IF OVER 10 PAGES

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AUTHORIZATION TO RELEASE MY HEALTH INFORMATION

I, ______________________________, authorize ______________________________
(Patient's name) (Physician/Facility)

____

I hereby request that my medical records be sent to Dr. Joseph M. Sperduto.

[ ] All my health information for the past 3 years; [ ] All my health information

[ ] My health information relating to the following treatment or condition: ______________________

[ ] My health information for the date(s): ____________

[ ] Other: ____

____

The following items must be initialed to be included in the use or disclose of other health information:
_____ HIV/AIDS related health information and/or records
_____ Mental health information and/or records
_____ Drug/alcohol diagnosis, treatments, and/or referral information (Federal regulations require a description Of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of Such information).

The information contained in this authorization and any document attached to it is confidential and may be legally privileged. It is intended solely for the use of the addressee. Access to this information by anyone else is unauthorized. Medical records are not to be distributed to any other physician, attorney, party, etc until you contact Dr. Joseph M. Sperduto's office to obtain a written authorization.

If you are not the intended recipient, you are hereby notified that any disclosure, discrimination, duplication or distribution of this information is strictly prohibited and may be unlawful.

If you are not the intended recipient, please:

- Destroy all copies of this message.
- Notify our office immediate at the number listed above

______________________ ______________________
Patient Signature Date

______________________ ______________________
Patient Name Date of Birth