ROY Z. BRAUNSTEIN, M.D., P.A.

OPHTHALMOLOGY ----------

ROY Z. BRAUNSTEIN, M.D.

MEDICAL RECORD RELEASE FORM

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the HIPAA privacy regulations. If any field is left blank the authorization will be considered invalid

Patient Name: _____

Date of Birth: _____ SSN#: _____

Patient Address: _____

City, State, Zip: _____

Phone #: _____ Cell #: _____

I authorize Dr Roy Z Braunstein M.D., P.A. to release of my health information to:

Facility, Agency, or Individual(s) authorized to RECEIVE my Health Information:

Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

Health Information that may be disclosed:

☐ **All Medical Records** ☐ **Specific Records: (specify) _____**

Health Information is limited to the following Treatment Date(s):

Please indicate all records or specify treatment date(s) here: _____

Your Health Information identifies you (the patient) by name and includes other demographic information about you. By signing below you are authorizing permission to release your medical information to the above named and you hereby discharge Dr Roy Braunstein and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status and/or psychiatric diagnosis that may have been compiled during your visit, encounter or hospitalization, or the making of copies thereof with the policies of this office. This authorization will automatically expire 60 days after the date indicated below, unless otherwise indicated. You understand that you have the right to revoke this authorization at any time, in writing, as stated in our Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

Authorized Signature: (Guardian/Minor) _____

Witness: _____ Date: _____

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