Authorization for Release of Protected Health Information (PHI)

Last Name:_____ First Name:_____ MI:_____

Date of Birth: Month_____ Day_____ Year_____ Social Security #:_____-_____-_____

Phone Number (_____)_____ Email_____

I hereby authorize disclosure of my Protected Health Information (PHI) as follows (check all that apply):

- ☐ Complete Medical Record for all services to include: History & Physical Exam; Progress Notes; Laboratory Tests, Physician Orders, X-Ray reports, Inpatient Admissions, Physical Therapy.
- ☐ Records related only to the following date(s) of service: _____

The Purpose of this release of information is for:

- ☐ Transfer of Records to David L. Kamelhar, MD, PLLC
- ☐ Personal Use
- ☐ Other (Describe)_____

I understand the following (Please read and check all statements):

- ☐ I understand that my records are protected under HIPAA /PHI regulations.
- ☐ I understand that under the Federal Protected Health Information (PHI) regulations, I have the right to review my record and request amendments where appropriate.
- ☐ I understand that my health information may be subject to re-disclosure and not protected by federal or state statues (medical emergencies, reporting of communicable diseases as required under State Law and government agencies upon appropriate and authorized court orders)
- ☐ I understand that the specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals and /or a history of testing or treatment of acquired immune deficiency syndrome(AIDA) or related conditions.
- ☐ I understand that there is a fee as permitted under New York State Regulations for copying medical records.
- ☐ I understand that I may revoke this authorization at any time by written notification, except that revocation will not cancel any action taken upon the original Authorization for Release of PHI.
- ☐ I understand that this Authorization of Release will expire in 180 days from the date signed.

Release of information From:

David L. Kamelhar, MD, PLLC
Eric S. Teller, MD
Kamelhar-Teller Pulmonary Medicine
38 East 32nd Street, Suite 601
(at Park Avenue South)
New York, NY 10016
Tel: 212-685-6611 / Fax: 212-685-6626

Release of information To:

_____
_____
_____
_____
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Signature:_____ Date:_____