SNA MEDICAL

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Medical Records Release Form

Date: _____

I, _____ DOB: _____

authorize release of my medical information to SNA Medical PC , 1711 Sheepshead Bay Rd, Brooklyn, NY 11235, tel 718-615-0014, fax 877-739-5368, email: info@snamedical.com

_____

(Name of Physician, Practice, Facility, etc. with phone number if known)

_____

(Name of Physician, Practice, Facility, etc with phone number)

The information to be released is (state specific documents, time period, etc.):

_____

◯ Progress Notes, ◯ Consultation Report, ◯ Medication Record, ◯ Radiology Reports

For a period from __/__ /___ to __/__/___

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____ _____

Patient/Parent/Legal Guardian Signature Relationship Date

_____ _____

If signed by other than patient, state relationship and reason for patient's inability to sign.

_____

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

_____