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Diane M. Sanfilippo, MD

Patient Authorization for Disclosure and Release of Protected Health Information

Please read this entire document before signing. Print Clearly. Sign and date at the bottom.

This HIPAA Compliant Authorization form is provided to assist you in having copies of the Protected Health Information (PHI) in your medical record forwarded to a different physician, or any other person. By signing below you authorize the Custodian of Records to release PHI about you to the person, office, or entity in Section 11.

Section 1: PRINT FULL NAME, DATE OF BIRTH, CURRENT ADDRESS AND PHONE NUMBER

NAME: _____ **D.O.B** _____
ADDRESS: _____ **PHONE:** _____
CITY: _____ **ZIP:** _____

Section 2: WHO DO YOU WANT INFORMATION SENT TO

I request and authorize Diane M. Sanfilippo, MD OB-GYN to release Protected Health Information about me to:

NAME OF DOCTOR or MEDICAL FACILITY: _____
ADDRESS: _____ **CITY:** _____ **ZIP:**_____
PHONE# _____ **FAX#:** _____

Section 3: WHAT INFORMATION DO YOU WANT SENT? CHECK ALL THAT APPLY!

__ All records contained in files except HIV Status, Mental Health, Chemical Dependency
__ Most recent exam notes and diagnostic tests
__ All records relating to_____ Surgery
__ Records pertaining to HIV Status (signed NY 2557 Form Required)
__ Mental Health Records (including anxiety/depression)
__ Chemical Dependency Records (including alcohol or substance abuse)
__ Other _____

Section 4: REASON FOR DISCLOUSRE of PHI _____ Transfer of Care _____Coordination of Care

*This authorization will expire in 90 Days and can be revoked at your request. You do not have to sign this request to receive treatment. After disclosure pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no long be protected by Federal HIPAA Privacy Rules.

*There is a fee of $.75 per page for all copies and faxes. Additional delivery fees may apply. Requests for "all records" may result in significant charges. Fees are due prior to processing. Processing and delivery may take up to 14 business days from the date of payment. You will be billed if payment is needed prior to processing.

SIGNATURE: _____ **DATE:**_____
LEGAL GUARDIAN: _____ **RELATIONSHIP:** _____

OFFICE USE ONLY:
Fees $.75 per page # of Pages_____ x .$75 _____ _____
Delivery Option ___ Fax up to 10 pp n/c _____ Mail $2.00-$10.00 _____CRR $12.00 + _____
Payment information: Cash / Check_____ CC# _____ Exp. _____ CRV TOTAL = _____