Suffolk: 1350 Deer Park Ave **North Babylon, NY 11703** **Phone: (631) 482-1355**
Suffolk: 281 Middle Country Road **Middle Island, NY 11953** **Phone: (631) 345- 6670**
Nassau: 1070 Old Country Rd **Plainview, NY 11803** **Phone: (516) 364-8600**
Nassau: 6175 Sunrise Highway, **Massapequa, NY 11758** **Phone: (516) 804-2100**

HEART & HEALTH MEDICAL

Patient Name: _____

Cell Phone:: _____ **Date of Birth: _____**

Email: _____ **Home Phone**:_____

Authorization for Release of Medical Information

I hereby authorize medical record release of:

Patient Name: _____ Date of Birth: _____

Please release the medical records from following medical providers:

_____

Estimate Cost of Medical records are $ 0.75 per page.

Total Cost:_____ Paid:_____

Information Released To:

_____

_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION.

2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. .I understand that medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Heart And Health, PLLC liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

PLEASE SIGN AND HAVE NOTARIZED BELOW:

Signature:_____

Print Name: _____

STATE OF _____ COUNTY OF _____

On this _____ day of _____, 20____, before me personally came _____, to me know and known to me to the individual described in and who executed the foregoing instrument, and (s)he acknowledge to me that (s)he executed the same.

_____ NOTARY PUBLIC STAMP & SEAL