



Authorization to release healthcare information

Patient's name _____ DOB _____

I request and authorize Dr. Flora Levin to release my healthcare information to:

Name _____

Mail to address _____

or Fax to _____ Attention _____

This request applies to healthcare information relating to the following treatment,

condition or dates ONLY: _____

I understand the following:

- 1) I may revoke this authorization by providing written notice to the office.
- 2) The practice will not condition treatment or payment based on my signing this form.
- 3) I am signing this authorization freely and under no pressure to do so.
- 4) The information disclosed in this authorization may be subject to re-disclosure by the practice and may be no longer protected by federal law.
- 5) I acknowledge that I have had an opportunity to review this authorization and understand it's intent and use.

This authorization expires in 6 months from the date signed, unless otherwise specified by me.

Patient signature _____ Date _____

Parent/ guardian name/signature _____

Relationship to pt. _____ Date _____

