# AUTHORIZATION **TO RELEASE MEDICAL RECORDS**

I, _____, HEREBY AUTHORIZE, DR. JOSEPH K. LEVENO, TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION TO:

_____
name of physician, hospital, insurance co., or self

_____
address

_____
telephone number/fax number

_____ SPECIFIC DATES OF SERVICE (Dates: _____)
_____ ALL MEDICAL RECORDS

THIS PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS OF DR. JOSEPH K. LEVENO AT THE REQUEST OF THE PATIENT.

_____
_____
(DECSRIBE HOW PROTECTED HEALTH INFORMATION WILL BE USED)

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECTIVE UNTIL 90 days from date signed, AT WHICH TIME THIS AUTHORIZATION TO USE OR DISCLOSE THIS PROTECTED HEALTH INFORMATION EXPIRES.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING AND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT DR. JOSEPH K. LEVENO HAS RELIED ON THE INFORMATION OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDICSLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. DR. JOSEPH K. LEVENO WILL NOT CONDITION MY TREATMENT, PAYMENT, OR ELIGIBILITY FOR BENEFITS WHETHER I PROVIDE AUTHORIZATION FOR THE REQUESTED USE OF DISCLOSURE. . I UNDERSTAND THAT MY RECORDS ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN AUTHORIZATION EXCEPT WHEN PERMITTED BY LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION. DR. JOSEPH K. LEVENO WILL NOT RECEIVE COMPENSATION FOR THIS USE OR DISCLOSURE FROM ANOTHER ENTITY.

_____
Signature of patient or parent or legal guardian

_____
Date

_____
Name of patient of personal representative

_____
Description of personal representative's authority