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Authorization for Request of Information Release

Patient Name: _____Date of Birth: _____

Address_____

Home Phone ( ) ____-_____Social Security #_____

I request Dr. Honig release the following protected health information:
____Entire Record or _____Labs.

I request _____ to release my protected health information: _____Entire Record or _____Labs to Dr. Honig.

The protected health information may be disclosed to (Name/Address/Telephone/Fax # of Physician or Self)

Name: Telephone/Fax#:

Address:

This request is made for the purpose of:
_____Seeking a second opinion
_____Relaying information to my Primary Care Physician
_____Seeking care from a Specialist
_____Transferring permanently from your practice
_____Obtain records for self possession

*__**A processing charge of $22.18, plus .73 per page applies to lawyers or insurance companies requesting patient records. Patients requesting records for self-possession or transferring to another physician may be charged .73 per page. Additional fees for postage and handling may apply.**__

Amount Charged $_____ Amount Paid $_____

- I understand that, as set forth in Dr. Honig, Notice of Privacy Practice, I have the right to revoke this authorization, in writing, at any time by sending written notification to the address above.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand I have the right to:
    1. Inspect or copy my protected health information to be used or disclosed as permitted under federal or state law.
    2. Refuse to sign this authorization.

_____
(Signature of Patient/Parent/Date)

_____
(Witness/Date)