HIPAA Medical Records Release Form

Patient Name:_____**Date of Birth:**_____

Patient Address:_____

Phone Number:_____**Patient Email:**_____

Authorization for Disclosure of Information: I authorize the office of Dr. Erica Rotondo to disclose my health information during the term of this Authorization to the recipient(s) I have identified below:

Institution Name:_____Phone:_____

Institution Address:_____

Institution Fax Number (required):_____

Purpose: I authorize the release of my health information for the following specific purpose:
_____
(Note: "at the request of the patient" is sufficient if the patient is initiating the Authorization)

Information to be Disclosed: I authorize the release of the following health information: (check the applicable box below)
____All of my health information including medical history, mental or health condition or any treatment received by me
____Only the following records or types of information:_____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Fax this form to (844) 278-8619. For questions call (760) 205-1050 or email doctorrotondo@gmail.com