SCHWARZBEIN
INSTITUTE

Request and Authorization for Release of Health Information to Another Provider ("Authorization")

Diana Schwarzbein, MD, d/b/a The Schwarzbein Institute, is hereby requested and authorized to release to the below named Healthcare Provider or Institution ("Provider") copies of the below described health records ("Records"), as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

Patient's Name: _____

Pt/Med Records # _____ **D.O.B.** _____

Name and Address of Provider:

_____

_____

Attn: _____

Provider Phone: _____ **Provider Fax:** _____

Request and Authorization

Treatment Dates to Which this Authorization Relates: _____

Health Records to Which this Authorization Relates:

- ❑ Laboratory Results
- ❑ Other Diagnostic test Results
- ❑ Operative Reports
- ❑ Other: _____

  _____

I understand you may charge a reasonable fee for copying and mailing the records, but will not charge for time spent locating the records.

I look forward to your sending the above records within 30 days of the date hereof, as specified under HIPAA. If my request cannot be fulfilled within 30 days of the date hereof, please so inform me by letter and state the date I might expect to receive my records.

The above requested Health Records may be provided to Provider, as follows:

- ❑ By USPS first class mail to Provider's address, as above
- ❑ By fax to Provider's fax number, as above

_____ _____

Patient's Signature **Date**