Svetlana Sakirsky, NP in Family Health, PC
2280 Grand Ave., suite 203
Baldwin, NY 11510

Authorization for the Release of Information

I, _____, hereby authorize the use or disclosure of my health information from the listed health practitioner as described below to the requesting practitioner.

Patient Information

Name_____DOB_____
_____

Address
_____

City_____State_____ Zip code_____

Phone _____Fax _____

I authorize for _____(practitioner`s name) to release and disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Duration: This authorization shall became effective immediately and shall remain in effect until _____(date) or for 1 year from the date of signature if no date is entered.

This authorization may be revoked in writing by undersigned at any time prior to the release of information from disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Check the box and initial which type of information is to be released/disclosed.

*_____ General medical information from_____to_____(dates)
*_____Laboratory tests from_____to _____(dates)
*_____Information regarding specific diagnosis and treatment from_____to_____
*_____Other_____from_____to_____
_____

Requesting Practitioner Information

Name_____

Street Address_____

City,State_____

Phone_____Fax_____

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Patient Name (print)_____

Signature of Patient_____Date_____