Brian A Levitt MD, LLC Medical Records Release

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Street Address _____City _____ State____ ZIP _____

Your Phone Number _____

DOCTOR WHO HAS YOUR RECORDS

I, _____hereby authorize Dr Brian A Levitt, MD, LLC to release my records:

PROVIDER YOU WANT TO RECEIVE YOUR RECORDS

Provider Name _____

Street Address _____City_____ State____ ZIP _____

Phone Number_____Email(required)_____

Medical records to be released: (please check all that apply) ☐ Entire Medical Record* ☐ Other (specify):_____

For treatment dates from _____to _____

* I understand that the protected health information (PHI) I am requesting may include disclosure of information regarding HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, genetic information/testing or mental illness. I authorize the release or disclosure of this information.

• By signing below, I acknowledge that: I may revoke this authorization in writing, but it will not affect disclosures/ transfers already in progress made with this authorization.

• I can receive a copy of this authorization upon request.

• A photocopy or scanned image of this authorization may be used in lieu of the original.

• I understand that recipients may not be subject to federal law and disclose information which I have authorized them to receive.

Signature: _____Date:_____

If signed by a personal representative of patient, print name and relationship to patient:

Name: _____Relationship: _____

Fax completed form without cover sheet to 770 394 5313

OR Scan and email to BrianLevittRet@yahoo.com