

**AUTHORIZATION TO DISCLOSE/RECEIVE MEDICAL RECORDS AND SHARE INFORMATION**

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize Toby R. Meltzer M.D., P.C to discuss, receive and convey medical information

with \_\_\_\_\_  
*(name of person with whom we are sharing information)*

for \_\_\_\_\_  
*(name of patient)*

The following information will be used on my behalf for the following purpose(s):

\_\_\_\_\_

**To establish a patient/physician relationship and for continuing medical care.**

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

- All hospital records (incl. Nursing records and progress notes)
- Transcribed hospital reports
- Medical records needed for continuity of care
- Most recent five-year history
- Laboratory reports
- Pathology Reports
- Diagnostic imaging reports
- Clinician office chart notes
- Dental records
- Physical therapy records
- Emergency and urgency care records
- Billing statements

**Other – TO DISCUSS MEDICAL INFORMATION OVER THE PHONE AND ASSIST WITH TRANSLATION.**

- HIV/AIDS-related records *(Must be initialed to be included in other documents)*
- Mental health information *(Must be initialed to be included in other documents)*
- Genetic testing information *(Must be initialed to be included in other documents)*

Drug/alcohol diagnosis, treatment or referral information: *Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information:*

\_\_\_\_\_  
\_\_\_\_\_

This authorization is limited to the following treatment: \_\_\_\_\_

This authorization is limited to the following time period: \_\_\_\_\_

This authorization is limited to a worker’s compensation claim for injuries on \_\_\_\_\_  
*(date)*

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of patient or person authorized by law)