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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

[ ] I hereby authorize Bindu or Sudipta Dey, M.D. to **review/release** information to:

[ ] I hereby authorize Bindu or Sudipta Dey, M.D. to **obtain** information from:

LIST PERSON OR ORGANIZATION, ADDRESS, CITY, STATE & ZIP CODE

PATIENT NAME_____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____

_____

SIGNATURE_____

Dates of Treatment to be released_____

Specific Information to be released: (please initial each that you are authorizing to be released)

DISCHARGE SUMMARY _____	LABORATORY REPORTS_____	EMERGENCY DEPT. RECORDS_____
OPERATIVE REPORT _____	X-RAY REPORTS _____	PHYS. THERAPY NOTES _____
CONSULTATION REPORT _____	PATHOLOGY REPORT _____	OTHER (SPECIFY) _____
		_____

Purpose of disclosure/use of protected health information_____
(not required if information is being released to patient)

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PLEASE NOTE, AS OF MAY 19, 2009:
For all copies requested of patient charts, there will be a $0.65 per page charge (plus postage, if mailing). This charge will be in effect for any patient requesting their chart to bring to a new physician, or for any requesting service, the fee will be billed to the requesting party. _____

PATIENT SIGNATURE