

Brian Bezack, DO, PLLC
Pediatric Pulmonary Medicine
Commack, NY

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

Appointment Date/Times Diagnosis X-ray Results Medications

Lab Tests/Results Summary of Medical Record Care Plan

Other (specify): _____

Indicate Confidential Information: Mental Health HIV information

Alcohol/Drug Information

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

_____ (specify expiration date or event)

NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Brian Bezack, DO, PLLC the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature: _____ Date: _____

Relationship to Patient

(If signed by personal representative of Patient): _____