AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION TO

MARTIN G GREGORIO MD AND ASSOCIATES

Patient Name:_________________________________ Date of Birth:__________

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider to disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Healthcare provider name: _____________________________________

Address: ____

Fax: _____________________________ Phone: _________________

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: Martin G Gregorio MD and Associates

Address: 1500 Village Run Road, Suite 308 Wexford PA 15090

Fax: 724-934-3388 Phone: 724-934-1900

Purpose: I authorize the release of my health information for the following specific purpose: (check the applicable box)

- ° Further Medical Treatment
- ° Personal Use
- ° Legal
- ° Disability benefits

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Patient Name:________________________________ Date of Birth:__________

Information to be disclosed: I authorize the release of the following health information: (check the applicable box/es below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history or physical condition and any treatment received by me.

- ❑ Specifically protected information by state/federal law. Substance Abuse records/Mental health records/HIV/AIDS related information

- ❑ Only the following records or types of health information: ____.

Term: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until the _____ day of ________, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: ____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____________________________ __________________
Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

_______________________ ______________ _______
Name of Guardian/ Representative Legal Relationship Date

05.11