AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Medical Associates of the Hudson Valley, P.C. to use or disclose my protected health information as indicated below:

PATIENT INFORMATION	
LAST NAME	FIRST
DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	
CITY	STATE, ZIP
DAYTIME PHONE NUMBER ( )	

PHYSICIAN	
☐ CRAIG MOSS, M.D.	☐ MARC TACK, D.O.
☐ DEBRA KARNASIEWICZ, M.D.	☐ CHARLES KUTLER, M.D.
☐ MICHAEL SHERAN, M.D.	

RELEASE RECORDS TO	
NAME	
ADDRESS	
CITY	STATE, ZIP
PHONE	FAX
REASON FOR REQUEST: ☐ TRANSFER CARE ☐ VISIT WITH SPECIALIST	☐ PERSONAL RECORDS ☐ OTHER _____

I UNDERSTAND THAT:
THIS AUTHORIZATION IS VALID ONE YEAR FROM THE DATE SIGNED BELOW.
TO RELEASE A COPY OF MY MEDICAL RECORD, THE COST AS PER THE PUBLIC HEALTH LAW IS .75 CENTS PER PAGE PAID IN ADVANCE.
PLEASE ALLOW TWO WEEKS FOR COPIES.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.

X	
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (SIGNATURE)	DATE OF SIGNATURE
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (PRINTED NAME)	RELATIONSHIP OF OTHER THAN PATIENT
X	
WITNESS (SIGNATURE)	DATE OF SIGNATURE