Dr Stefana Pecher, LLC

Country Doc Walk-In & Wellness LLC

(P) 860 535-4600 (F) 860 535-4605

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Stefana Pecher, MD to disclose the following protected health information from the medical record of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Date: ________________ **Patient Name:** ____ **Date of Birth:** ____________

Address: ____
Street City State Zip

Home Phone: _____________________ **Alternate Phone:** _____________________ **Email:** ____________________________

Information to be disclosed to: ____

Address: ____
Street City State Zip

Phone: _________________________ **Fax:** ______________________

Disclose the following information for treatment dates from: __________________________ **to:** ________________________

☐ Abstract ☐ Discharge Summary ☐ Consult ☐ Operative Report ☐ History & Physical ☐ EKG ☐ Emergency Reports
☐ Outpatient Reports ☐ Laboratory ☐ X-ray Report ☐ Pathology ☐ Therapy (OT, PT, Speech, Audiology, Cardiac Rehab)
☐ Spirometry ☐ Other Specified: ____

The above information is disclosed for the following purposes:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Continuity of Care ☐ Other: ___________________________________

I understand I may revoke this authorization at any time by requesting such from in writing, unless it has already been acted upon, or during a contestability period under applicable law. This authorization expires upon completion of this request.

____ ____

Signature of Patient or Legal Representative Date Time

____ ____

Printed Name of Patient or Patient's Representative Relationship to Patient or Authority to Act for Patient

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→ → **Protected Health Information** If the information in this section pertains to your treatment, you must complete and sign for your request to be processed. I authorize release of protected information by checking the following:

☐ Psychiatric Information ☐ AIDS/HIV Information or Test Results ☐ Social Services Notes ☐ Drug Treatment/Testing

☐ Alcohol or Test Results ☐ Sexual Physical Abuse ☐ Socially Transmitted Disease/Test Results ☐ Genetic Testing

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____ ____

Signature of Patient or Legal Representative Date Time

____ ____

Printed Name of Patient or Patient's Representative Relationship to Patient or Authority to Act for Patient

7/2015