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DR. AUGUST PASQUALE, M.D.
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Authorization for Release of our Medical Records

Date: _____

I authorize to disclose my health information to: _____

My health information should be sent to:
Contact: _____
Address: _____
Phone : _____ Fax: _____

I understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable state guidelines. By signing this authorization, I agree to pay these fees at the time of this request.

Patient Name: _____
Date of Birth: _____
Address: _____

Signature: _____ Date: _____
Relationship to patient (if not self): _____

For (circle one): healthcare agent / guardian / surrogate / parent / personal representative of deceased I, _____, am the representative for the patient as circled above.
Representative's signature: _____
Address: _____ Phone: _____

If you are the healthcare agent or guardian or court appointed Personal Representative of the deceased, please attach proof of your authority to act on behalf of the patient.
By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires additional authorization.

Notice to the recipient of these records: If the information concerns a person treated for alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 42 CFR part2) and prohibits further disclosure of this information except with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose.