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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient name:_____

Patient address:_____

Patient email:_____

Patient date of birth_____

I request that Lawrence A. Smiley, M.D., provide a summary of my health information regarding my care and treatment to be faxed or mailed to my new physician, named below:

New physician name:_____

New physician address:_____

New physician fax #:_____

I understand that in accordance with NYS law and HIPAA that this authorization may include the disclosure of sensitive personal and private information, including alcohol & drug abuse, mental health issues, psychological or psychiatric diagnoses & treatment, and confidential HIV/AIDS infection related information and any other information that I gave to Lawrence A. Smiley, M.D., and the results of any tests or studies that Lawrence A. Smiley, M.D. performed on me or ordered on my behalf and that the release of this information may cause shame, embarrassment, remorse or regret.

I have the right to revoke this authorization at any time by notifying Lawrence A. Smiley, M.D., in writing, by email or fax.

I understand that my signing this authorization is voluntary and that if I do not sign this authorization, my health information will not be released.

I may see and request a copy of the information described on this form if I ask for it. I agree to pay any reasonable fees associated with copying of records. I also understand that any review of original medical records will be supervised by Lawrence A. Smiley, M.D..

I understand that the authorized health information may be electronically communicated to my new physician's office and/or to me by fax transmission.

SIGNATURE OF PATIENT

DATE SIGNED