Antonios J. Tsompanidis, D.O.
A PROFESSIONAL CORPORATION

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Authorization for Release of Protected Health Information

Patient Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Date of Birth: ______________ Telephone: (_____) ______________

I hereby authorize and request Antonios Tsompanidis, D.O. PC to:

☐ **RELEASE INFORMATION TO:** **OR** ☐ **OBTAIN INFORMATION FROM:**

Name/Facility: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Telephone: (_____) ______________ Fax: (_____) ______________

FOR THE PURPOSE OF:

☐ Continuation of Care ☐ Transfer of Care ☐ Insurance (Life or Health)
☐ Personal Reasons ☐ Other (Please Specify) ______________

SPECIFIED REPORTS:

☐ **Complete Medical Records** ☐ Consultation Report(s) ☐ Operative Report(s)
☐ Lab Report(s) ☐ Doctor's Note(s) ☐ History & Physical
☐ Discharge Summary ☐ Imaging Report(s) ☐ Other______________

I understand that the information to be disclosed includes my identity, diagnosis and treatment including but not limited to ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED AND INFECTIOUS DISEASES, AIDS AND HIV information as applicable.

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies and faxed copies of the information directed in this authorization. I further agree to release the facility and its employees and agents from liability that may arise from the release of information herein requested.

I understand that this authorization is subject to revocation at any time except for the extent that the individual or entity that is to make the disclosure has already taken action to reliance upon it.

I also understand and agree that this authorization will terminate only upon execution of my written statement indicating my intent to revoke this authorization and that without such written revocation this authorization will expire in 6 months from the date of signature.

______________________________ ______________
Signature of patient or legal representative Date

______________________________ ______________
Witness (Print and Sign) Date