Dr. Kathy Santoriello MD PA

900 East Ocean Blvd #330D
Stuart, FL 34994-2471
Phone: (772) 419-0505 Fax: (772) 781-7327

Authorization for Release of Medical Information

Patient's name: ____________________ Date of Birth: ____________
Address: ____________________
City/State/Zip Code: ____________________
SS#: ____________________ Patient's phone #: (   ) ____________
Date of Request: ____________ **Date Needed:** ____________

☐ I authorize the Dr. Kathy Santoriello MD PA **to release information to**:	OR	☐ I authorize Dr. Kathy Santoriello MD PA **to obtain information from**:
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Phone #/Fax # (include area code)		Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)
☐ Immunization history ☐ Administered by Dr. Santoriello only. ☐ Include records submitted to Dr. Santoriello.
☐ All medical records related to a specific illness or injury**.**

Specify illness/injury ____________________ Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
☐ Specific information (Select one or more, as applicable)
☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results
☐ X-ray reports ☐ Other ____________________
(Please describe.)

☐ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)
☐ This request only.
☐ One year from the date of this authorization **OR** ____________ **.** (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until: ____________
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Released medical records may include HIV-related information, mental health related care, substance abuse diagnosis and treatment, sexually transmitted disease information, pregnancy information. I agree to the inclusion of this information ________.
Initial
- There may be a charge for the requested records.

Signature of Patient or Representative ____________________ Date ____________
Relationship to Patient *(if requester is not the patient)* ____________________

Distribution: Original to medical record. Copy to requester, as required.