**DANIEL L CASSIS MD PA**
4302 ALTON ROAD SUITE 100 | MIAMI BEACH, FL 33140
Phone: (305) 535-7404 | Fax: (305) 535-7408 | info@drdanielcassis.com | www.drdanielcassis.com

# Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient's Name: ___________________________________________ Date of Birth: __________________________

Telephone Number: ________________________________________ Social Security #: _______________________

I request and authorize the custodian of records of the patient named above to disclose/release the following information* (check all applicable)

☐ All Records ☐ Laboratory/Pathology Records

☐ X-ray/Radiology Records ☐ Billing Records

☐ Abstract/Summary ☐ Pharmacy/Prescription Records

☐ Other (describe specifically) :

___________________________________________________________________________________________________

___________________________________________________________________________________________________

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure if this information.***

**Definition**: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Please fill in below the physician we are obtaining your records from:

Physician or Hospital:_______________________________________________________________________________

Address:_________________________________________________________________________________________

City, State, Zip Code:________________________________________________________________________________

Telephone Number:_________________________________________________________________________________

Fax:_____________________________________________________________________________________________

The information may be used and disclosed for each of the following purposes:

☐ At my request (only the patient can check this box) ☐ For my health care

☐ For payment/insurance ☐ For employment purposes

☐ Other: ________________________________________________________________________________________

This authorization will expire 90 days from today or: ________ /________ /_______ (whichever is sooner)

I understand this authorization is voluntary. I understand once the custodian of records discloses my health information herein disclosed, it may no longer be protected by federal privacy laws. I further understand I may refuse to sign this authorization. My

Initial_______

refusal to sign **will not affect** my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of the protected health information.

Patient/Representative
Signature: ________________________________________________________________

Date signed: ________________________________________________________________

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the office of Dr. Daniel L Cassis MD PA, 4302 Alton Road Suite 100, Miami Beach, FL 33140.

**A copy of this signed authorization must be given to the individual.**