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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Dr. Timothy Teslow to:

( ) Release information to: **( ) Obtain information from**

_____
(Person or Facility/ Dr.)

_____
(Address) (City) (State) (Zip)

_____ _____
(Phone) (Fax)

PATIENT INFORMATION

_____ _____ _____
(Patient Name) (Date of Birth) (Phone)

_____
(Address) (City) (State) (Zip)

INFORMATION REQUESTED

Dates of requested records: _____ to _____ including:

( ) Chart Notes
( ) History & Physical
( ) X-Ray Reports
( ) Lab Reports
( ) OP Reports
( ) Pathology Reports
( ) Other _____

Purpose for request: ( ) Self ( ) Continued Care ( ) Other _____

I understand information in my health record may include information relating to Sexually Transmitted Disease, AIDS, HIV, or other communicable disease, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse or genetic testing. My signature authorizes the release of any such information. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand if this information is disclosed by the person or organization that receives the information, I release Timothy W Teslow, MD, PC employees, medical staff, members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized here in.

****A copy of the original signed release should be treated as an original.**

_____ _____
(Signature of Patient/Guardian) (Date of Signature)

ID VERIFIED ( ) _____ _____
(Witness Signature)