ROBERT J. MARO. M.D., P.A. & ASSOCIATES

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Authorization to Release Health Information

(Please complete all sections)

1. Patient Information

Patient's Full Name ____________________ Date of Birth ____________

Patient's Address ____________________ Patient's Home Phone Number ____________________

City, State Zip Code ____________________ Patient's Work Phone Number ____________ Cell Phone Number ____________

2. Health Information Release Instructions

Information to be Released FROM:

Practice/Physician's Name ____________________

Address ____________________

City, State, Zip Code Telephone ____________________

Information to be Sent TO:

Name (Patient - Practice - Company) ____________________

Address ____________________

City, State Zip Code Telephone ____________________

3. Authorization

I,______________________________, do hereby authorize ____________________________
to release my "Heath Information", as defined below: (Check One)

_____ All Medical Records

_____ All Medical Records from ______________________ through ____________________
(Date) (Date)

_____ All Medical Records EXCEPT ____
(List Exceptions)

_____ All Medical Records Pertaining to ____
(List conditions, treatments or type of medical records)

NOTICE: Unless excluded above, this Authorization is for FULL DISCLOSURE OF ALL RECORDS. I acknowledge that such information may include the testing, diagnosis and/or treatment of HIV, AIDS, sexually transmitted diseases, mental health/psychiatric care, or alcohol and/or drug abuse.

4. Purpose of Information Release

O Information for continuing care by Primary Physician
O Disability Determination O Workers Compensation O Personal Injury

5. HEALTH INFORMATION PROTECTION AND PORTABILITY ACT (HIPPA) DISCLOSURES

The Recipient of this Health Information may not use or disclose the Health Information unless another authorization is obtained from me or unless such use or disclosure is specifically required to permitted by law.

This Authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this Authorization. Unless otherwise revoked, this Authorization will expire ninety (90) days from the date signed below. This Authorization if fully understood and is made voluntarily on my part.

SIGNATURE: O Patient O Parent O Other ____________ Date ________ Witness ____________ Date ________