

ROY MICHAEL STEFANIK, DO

PSYCHIATRY

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RELEASE OF INFORMATION

PATIENT'S NAME: _____ DOB: _____

The patient listed above hereby authorizes

Roy Michael Stefanik, DO

to RECEIVE/DISCLOSE individually identifiable health information of the patient
(as described below) TO/FROM

Name of individual/organization

Address of individual/organization

Fax and phone number of individual/organization

Specific dates needed: _____.
These disclosures are for the purposes of (i.e., continued care, personal, etc.)

The specific records/reports to be disclosed shall include:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Lab | <input type="checkbox"/> Procedures or Operative |
| <input type="checkbox"/> Abstract | <input type="checkbox"/> Consultations | <input type="checkbox"/> X-ray (folder/PACS) | <input type="checkbox"/> Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Diagnostics | <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Disks/Tapes/Photos | <input type="checkbox"/> Pharmacy Profile | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Emergency Record | <input type="checkbox"/> Nursing Notes | <input type="checkbox"/> Other (specify type): _____ | |

Alcohol, drug, HIV, ARC and/or AIDS information, if present, will be disclosed at I have directed above. I understand this information is protected by federal and state confidentiality laws and may not be disclosed without authorization or unless required or permitted by law.

This information is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), or drug and/or alcohol abuse. I understand that I may revoke this authorization at any time. _____ (Initial)

I understand that unless earlier revoked, this authorization will expire on ___/___/___ or on the happening of _____ (if no date or event is specified, authorization will expire six (6) months after that date of signature below).

Patient

Date