Angelo J. Mattalino, M.D.

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Release of Protected Health Information

I, _____ authorize Angelo Mattalino, MD to disclose following information from the health records of

Patient Identification:

Last name: First: Middle:

Address:

Home phone #:	Cell phone #:

- ○ Billing Records
- ○ Progress Note(s)
- ○ Consultation(s)
- ○ History & Physical(s)
- ○ Entire/Medical Chart(s)
- ○ Operative Report(s)
- ○ Pathology Report(s)
- ○ X-Ray/MRI CD(s)
- ○ X-Ray/MRI Report(s)
- ○ Other:_____

Purpose:

Date of Service:

From (Start Date):	To (End Date):

Information to be sent to:

Address:

Phone #:	Fax #:

I authorize Angelo Mattalino, MD to release medical information regarding treatment and/or outpatient care. I understand that the information may include psychological or psychiatric impairment(s), drug abuse, alcoholism, infections, or contagious disease information, including HIV, and AIDS related confidential information. I understand that I may revoke this authorization of release of medical at any time, expect to the extent action has been taken in reliance on it and that in any event this authorization will expire 90 days from the state signed and/or as specified _____. I understand that if this information is disclosed to a third party, the information may no longer be protected by the state, federal regulation and may be re-disclosed by the person or organization that received the information. I may refuse to sign this authorization form and understand that Angelo Mattalino, MD will not condition or deny treatment on my signing this authorization. I release Angelo Mattalino,MD , and its employees and medical staff members from any legal responsibility for the disclosure of the above information to the extent indication and authorized herein.

Patient/Guardian signature Date