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AUTHORIZATION FOR RELEASE/RECEIPT OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ________________

Patient Address: ____

____

Phone Contact: **(Day)** ______________________________ **(Evening)** ______________________________

I, ____ do hereby authorize T. Atilla Ceranoglu, M.D. to obtain and release information including copies of my medical record of care received to and from the following person(s) or classes of persons (e.g., doctors, lawyers, etc.) at the locations/facilities listed, for medical care and insurance purposes:

Persons/Class of Person/Facility/Address *(Please use additional forms if more than four contacts are listed)*

1. Pediatrician:	2. School:	3. Other *(Specify)*	4. Other *(Specify)*

I understand that:

- I may withdraw my authorization at any time by submitting a written request to my doctor. Authorization may be withdrawn except for the following:
  - to the extend that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Dr. Ceranoglu.

I understand that this authorization will remain in effect while I am in treatment with Dr. Ceranoglu.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: ____ **Date:** ____________

Print Name: ____

Signature of Legal Representative: ______________________________ **Date:** ____________

Print Name: ______________________________ **Relationship to patient:** ______________