Record Release

Date: _____

I authorize you to release any and all of my medical records to Luthra Medical Associates.

Please send all records to:

Luthra Medical Associates
2075 Kensington Ave
Snyder, NY 14226

_____
Name Of Patient

_____
Signature Of Patient

_____
Date Of Birth

Patient Privacy Authorization

1. Please list any family members or other person(s), if any, whom we may inform of your general condition and your diagnosis:

_____

_____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition in an emergency. (If different from above)

_____

_____

3. May confidential messages (i.e. lab reports, X-ray results, appointments etc.) be left on your

- ❏ Home/ cell answering machine
- ❏ With family members

4. May we call you at work?

- ❏ Yes
- ❏ No
- ❏ N/A

5. If necessary, may we fax your protected health information to another doctor's office or to an insurance company? Please be advised that checking "No" may lead to significant delays in important communications regarding your health care.

- ❏ Yes
- ❏ No

6. Please list any other pertinent information you think this office should know regarding your privacy.

_____

_____

7. I am aware that a cellular phone is not a secure phone line.

_____ _____ _____

Print Name Signature Date