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AUTHORIZATION TO RELEASE OR TRANSER HEALTH INFORMATION

To Custodian of Records for Dr. Peter Levin:

I, _____, Date of Birth (if known), _____

Date of Visits (approximate), _____authorize you to furnish:

_____All health information pertaining to my medical history or physicial condition and treatment received that would appear relevant to my current and future care.

_____A copy of the entire medical record including registration forms and notations that are unlikely to help another provider evaluate and care for me.

Please send the records to (include address and fax if preferred:

_____
_____
_____

I release you from all legal responsibility or liability that may arise from this authorization.

I understand that charges may be assessed for providing records. Please mail or fax to the witnessed form to the address or fax above.

Witness _____ Signed _____

Date _____

Applicable Fees:

	Clerical	Copying	Delivery
Patient	$15	$0.25/page	Mailing Cost
Insurance Company	$15	$0.25/page	Mailing Cost
Medical institution	No fee	No fee	No fee
Medical/Medicare	No fee	0.25/page	Mailing cost