STANLEY H. SCHWARTZ, MD, INC.

Moreno Valley	**Banning**	**Riverside**
12980 Frederick St. Ste. I	*264 N. Highland Springs, Bldg.1 Ste.A & B*	*7724 California Ave*

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PLEASE PRINT CLEARLY

PATIENT NAME ______________________ **SOCIAL SECURITY NUMBER** ______________________

ADDRESS ______________________ **CITY / STATE / ZIP** ______________________

DATE OF BIRTH ______________________ **PHONE NUMBER** ______________________

I, ________________________________(Printed Name) authorize the entity/ organization named below to obtain my protected health information:

STANLEY H. SCHWARTZ MD, INC.
12980 Frederick St. Ste. I
***Moreno Valley,* CA 92553**
Phone: (951) 924 – 3244 Fax: (951) 243-6976

The following are authorized by me to provide such copies of the records:

☐ **ENTIRE RECORD** ☐ **SPECIFIC INFORMATION** ____________________ ☐ **OLD RECORDS FROM PREVIOUS**

The following individual or organization is authorized to make the disclosure:

NAME: ____

ADDRESS: ____

____

PHONE: ____

I understand that I have the right to revoke this authorization in writing. Unless, otherwise revoked, this authorization will expire on the following date, event or condition________________________(specify date of expiration). If I fail to specify an expiration date, event or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

______________________ ______________________
Signature of Patient or Legal Representative **Date**

______________________ ______________________
Relationship **Signature of Witness** **Date**

FOR OFFICE USE ONLY
Received: ______________________ **Completed by:** ______________________

Date Completed: ______________________ **Fee Paid (If applicable)**____________

Disclosure Consisted of :____

MONETTE/2015