

B.S. BONYO D.O. & ASSOCIATES INC.

Authorization for Release of Patient Information

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone Number(s) w=work, h=home, c =cell _____

How would you like to receive your records? Mail Email (Provide email address) _____

This following information is to be released from (please circle one):

B.S. Bonyo D.O. & Associates Inc.
1569 Vernon Blvd.
Akron, OH 44320
Fax: 330-867-7434

Description of information to be release: (please check all that apply)

- Entire Record Immunization Records Laboratory Reports Radiology/Imaging Reports
 Consultation Progress Notes Most recent history and physical
 Other _____

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This above information is to be disclosed to:

Provider (Doctor Name) _____ Fax# () _____

Address: _____

Description or the purpose of the use and/or disclosure:

- Continuing Care Second Opinion Social Security/Disability Personal Use
 Consultation/Referral Insurance Legal Purposes
 Other; Please Describe _____

I understand that this authorization is voluntary and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Premier Family Physicians has fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date of event).

I understand I may revoke this authorization at any time by notifying Premier Family Physicians. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

X _____
Signature of Patient or Patient's Representative Date Printed name of Patient or Patient's Representative

Relationship to Patient Legal Authority (Attach Supporting Documents)