DR. DAVID K. EMMEL
Authorization for Release and/or Disclosure of Health Information

I authorize the disclosure of my personal health information to the person or entity described below. I understand this authorization is voluntary and made to confirm my directions. I also understand that once the information is disclosed, it may be re-disclosed and is no longer protected by federal privacy regulations. I hereby give permission to the office of Dr. David K. Emmel to disclose my protected health information in the manner(s) described below.

PATIENT INFORMATION **Account #:** _____

Name: _____ **Birthdate:**_____/_____/_____

Address: _____

Phone Number: (_____) _____-_____ **Request Date:** _____

MY HEALTH INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone:** _____

Address: _____ **Fax:** _____

MY HEALTH INFORMATION MAY BE DISCLOSED TO:

Provider of Services: Dr. David K. Emmel **Phone:** (860) 721-8960

Address: 1260 Silas Deane Hwy Ste 110, Wethersfield CT 06109 **Fax:** (860) 563-2030

HEALTH INFORMATION TO BE DISCLOSED:

□ **General Medical Information from _____ to _____ (Treatment Date Span)**

□ **Medical Information Regarding Specific Treatment or Injury:** _____

_____ from _____ to _____ (Treatment Date Span)

□ **Other Medical Information (specify):** _____

Right to Revoke: I understand that I may revoke this authorization in writing at any time but my revocation will not affect any disclosures that occurred before the office of Dr. Emmel received and processed a written notice of revocation. To revoke this authorization, I understand that I must send a written request to Dr. David K. Emmel, 1260 Silas Deane Hwy Ste 110, Wethersfield CT 06109. I understand that if I didn't specify duration and if I do not revoke it, this authorization will expire one year from the date of signature below. Duration of Validity of this Authorization: _____

ACKNOWLEDGEMENT

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the content is accurate. I duly authorize and direct the office of Dr. Emmel to release my personal health information to the party indicated above.

Signature of Patient: _____ **Date:** _____

Printed Patient Name: _____ **Date:** _____

If you are not the patient, please also complete, sign, and date below. Check the box that describes your relationship to the patient and please attach proof or your relationship to the patient.

Signature of Non-Patient Requestor: _____ **Date:** _____

Printed Name of Requestor: _____ **Date:** _____

□ Parent of Minor Child □ Legal Guardian □ Power of Attorney □ Executor □ Other: