Fax Number: 631.670.7567

TIMOTHY D. GROTH, MD PC

Authorization to Obtain Health Information

Doctor, Hospital Facility: ____________________

Address: ____________________

Patient Name: ____________________

Address: ____________________

Phone Number: ____________________ Date of Birth: ____________

I authorize you to disclose health information of the above-named individual to:

Timothy D. Groth, MD PC
994 West Jericho Turnpike
Suite 104
Smithtown, NY 11787
Fax Number: 631.670.7567

Please select from below any information you would like to be sent to Dr. Groth to aid in your diagnosis and treatment. Please provide dates of service where it applies.

- ☐ Operative Report
- ☐ Anesthesia Record
- ☐ Discharge Instructions
- ☐ Discharge Summary
- ☐ EKG
- ☐ History and Physical
- ☐ Laboratory Results
- ☐ Consultation Reports from ______ to _______
- ☐ Medications Sheets
- ☐ Physicians Progress Notes from ______ to ______
- ☐ Physicians Orders from ______ to ______
- ☐ X-rays, MRI from ______ to ______
- ☐ Entire medical record
- ☐ Other: Specify ____________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse. For AIDS and HIV status, the department of Health Authorization must be completed instead of this authorization.

I understand that I have a right to revoke this authorization at any time; I must do so in writing and present my written revocation to Medical records. Unless revoked, this authorization will expire on the following date, event or condition.

____________________________________________

(You may indicate "none" if you wish to indicate a specific date)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain copies of the information to be used or disclosed, as provided in the applicable Federal and State law. If I have questions about the disclosure of my health information, I can contact the medical records department.

Signature of Patient: ______________________________ Date: ______________