Authorization to Release Medical Records

I hereby authorize release of medical records and other information as specified below to:

Jeffrey Kahn, MD, FAAPMR, CIME
rehabwoRx Physical Medicine and Rehabilitation, PLLC
5000 Brittonfield Parkway, Suite A-122, East Syracuse, New York 13057
Fax (315) 234-9680 Phone (315) 234-9679

Individual or organization listed below is authorized to release records as specified below:

Name:	**Title/Business:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Fax Number:**

Please specify what records should be released:

- ❑ All records including office notes and results of diagnostic studies.
- ❑ Insurance demographic information with with limited PHI.
- ❑ All records between the dates of _____ and _____.
- ❑ Records pertaining to _____.
- ❑ Records pertaining to psychological or psychiatric evaluation or treatment.
- ❑ Records pertaining to substance abuse evaluation or treatment.
- ❑ Records pertaining to HIV/AIDS status or treatment.

Please specify method of release:

- ❑ Pick-up by patient
- ❑ Send by fax
- ❑ Hand delivery
- ❑ Certified Mail
- ❑ Send by standard mail
- ❑ Phone call

Name:	**Title/Business:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Relationship to Patient:**

Patient/Guardian Signature: _____

Date: _____