16 Hospital Avenue, Suite 303
Danbury, CT 06810
Phone (203) 730-2900
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Z. Michael Taweh, M.D., P.C.

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name:	Phone Number:
Patient Street Address:	City, State and Zip Code
Birthday:	Social Security Number:

I hereby authorize the office of Z. Michael Taweh, M.D., to make uses and disclosure of my protected health information (information pertaining to my medical records and/or financial records) as indicated below.

The information is to be disclosed to:
Name:

Street Address:

City, State, Zip:

Description of Information to be disclosed:

For dates of treatment from ___________ to ___________.

Reason for requested use or disclosure:

- □ Transfer of health coverage
- □ Form completion
- □ Change in health care provider
- □ Personal use
- □ Referral
- □ Other: (Please list reason below.)

This authorization expires in 6 months from the date signed or earlier ___________ (state date).

To be read and signed by patient:

I understand the following:
a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so.
e. The information disclosed on this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
g. I will receive a copy of this completed and signed authorization form.

Patient Signature:	Date of Signature:
Signature of Patient’s Representative:	Relationship: Date: