MANHASSET PUBLIC SCHOOLS

Office of Human Resources
516.267.7730

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print):

Name: ___________________________________Date of Birth: _______________________

Address: ____

City: ____________________State: ________Zip Code: __________Phone: _____________

DISCLOSURE/RELEASE OF MEDICAL RECORDS:

I, _________________________do hereby authorize___________________________________

to disclose and release the following information related to my request:

____

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This information shall be provided to:

Dr. Ronald Marino, DO MPH
Medical Director
Manhasset Union Free School District

EXPIRATION: This authorization will expire one (1) year from the date hereof.

REVOCATION: I understand that I have the right to revoke this authorization, in writing, at any time by presenting my written cancellation to Dina Maggiacomo. I understand that a cancellation will not apply to information that has already been released under this authorization.

DISCLOSURE/REDISCLOSURE: I understand that by signing this authorization form I am authorizing the use or disclosure of my protected health information as described above and that this information may be re-disclosed if the recipient described on this form is not required by law to protect the privacy of the information.

PRE-CONDITION TO TREATMENT: I understand that my treatment cannot be conditioned on whether I sign this Authorization.

I HAVE COMPLETED EACH OF THE ITEMS ON THIS FORM AND A COPY OF THIS FORM HAS BEEN PROVIDED TO ME.

Signature of Patient: ________________________________ Date: ___________________