PETER J. SAKOL, M.D., L.L.C.
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Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name	Date of Birth	Social Security #

Address (street, city, state, zip code)	Telephone #

Peter J. Sakol, M.D., LLC is authorized to make the disclosure to the following individual or organization (Full name and address): _____

_____

I prefer to (check one):

___ Pick up medical record copies before September 30, 2024,

___ Have medical record copies mailed to the above name and address, or

___ Faxed to the above name and address (if possible) before September 30, 2024 - must provide fax number.

Detail of records to be released:

Treatment Dates	Purpose of Request

The following information is to be disclosed: (please check box for each item to be disclosed)

□ physician notes
□ lab results
□ pathology reports
□ x-ray reports
□ other _____
□ MRI scans / CT scans
□ cardiac studies
□ photographs
□ complete records

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights: (a) I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. (b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event, or condition, this authorization will not expire).

_____

Signature of patient or legal representative	Date

_____
(if signed by legal representative, relationship to patient)