CO RECOVER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Last Name: _____ First:_____ Middle_____

Date of Birth:_____

I authorize Edward J. Bilotti, MD and CoRecover, LLC to use or disclose my Protected Health Information to include all medical records, laboratory results, , medications, diagnoses, hospitalizations, and also to include any information regarding ALCOHOL AND DRUG USE AND TREATMENT, HIV/AIDS, OR MENTAL HEALTH as covered by 42 CFR Part 2. The purpose for this disclosure is to coordinate care with another provider or to communicate with a family member or other individual that I have specified below:

The following person(s) may receive the above described Protected Health Information about me:

Name:_____

Office or agency:_____

Title/relationship:_____

Address:_____

_____

Voice number:_____

Fax number:_____

_____ _____

Signature (Patient) Date

_____ _____

Signature (Legal guardian) Date