AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Last Name: _____ First Name: _____ Middle Initial: _____

RELEASE TO ELI ANKER, M.D., P.C.

I authorize the following healthcare provider(s) and its physicians, employees, and agents to release or disclose to Eli Anker, M.D., P.C. and its representatives, the complete history of my medical records including records pertaining to treatment, prognosis, and diagnosis, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, or HIV infection.

	Healthcare Provider	Address	Telephone #
1.			
2.			
3.			

I hereby authorize and request you to release to:

ELI ANKER, M.D., P.C.
754 Montauk Highway
West Islip, NY 11795

I understand that I may revoke this authorization at any time by notifying Eli Anker, M.D., P.C. in writing. My revocation will not have any effect on actions already taken in reliance on this signed authorization and prior to receipt of my written revocation.

_____ _____
Patient Signature Date

RELEASE FROM ELI ANKER, M.D., P.C.

I authorize Eli Anker, M.D., P.C. and its representatives, to release all medical records and personal information in its possession to the below individuals in an emergency situation or whenever deemed necessary by Eli Anker, M.D., P.C.

	Name	Relationship	Address	Telephone #
1.				
2.				
3.				

I understand that I may revoke this authorization at any time by notifying Eli Anker, M.D., P.C. in writing. My revocation will not have any effect on actions already taken in reliance on this signed authorization and prior to receipt of my written revocation.

_____ _____
Patient Signature Date