Lawrence Amesse, MD, PA

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize Lawrence Amesse, MD, PA to use and disclose all health and medical information relevant to my diagnosis and treatment _____
Name of Patient
to the following: _____For the purpose of diagnosis and
Name of Recipient
treatment of my medical condition. I also Authorize Lawrence Amesse, MD, PA and his representatives to leave messages including laboratory results on my voicemail/ answering machine even if confidential information might be overheard by others than myself.

Home Yes _____ No _____
Work Yes _____ No _____
Cell Yes _____ No _____

You have the right to revoke this authorization any time, provided you accept the extent that we have already used or disclosed the information.

I have reviewed and I understand this Authorization.

By: _____ Date: _____
Patient

Or By: _____ Date: _____
Patient's Representative

Description of representatives Authority: _____

I, _____, authorize Lawrence Amesse MD PA to furnish the above
Patient
information as is requested to the above Health Care Provider.

Signature _____ Date _____