Center for the Care of the Professional Voice

980 Westfall road
Building 100, Suite 127

Appointments: (585) 442-1110
Fax: (585) 730-8151

EXCEPTIONAL CARE FOR DISORDERS OF VOICE, SWALLOWING, BREATHING AND LARYNX CANCER

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request release of my Protected Health Information (HIP):

FROM: _____

_____

_____

TO: **Haben Practice for Voice & Laryngeal Laser Surgery**

980 Westfall Rd., Bldg.100, Ste. 127, Rochester, NY 14618

Phone: (585) 442-1110 Fax: (585)730-8151

This release allows the following specific PHI to be released: (include dates where appropriate)

_____ Complete health records _____ Lab results/X-ray reports

_____ Physical exam _____ Consultation reports

Other (please pecify:_____

The following statements are true:

1- This Authorization is voluntary.

2- I understand that Dr. Haben's office may not condition treatment of me on this Authorization.3

3- I understand that I may revoke this Authorization at any time in writing.

4- I understand that the information disclosed may be subject to further disclosure by the recipient, and that the PHI will no longer be protected by Dr. Haben's office after disclosure.

Patient Name:_____

Date of Birth: _____ Phone: (_____)_____

Address:_____

City: _____ State: _____ Zip: _____

_____ _____

Signature of patient or legal representative Date

Please fax records to 585-730-8151