Melville H. Hughes, M.D., P.C.
Tania Cohen, PA-C, MPAS

Patient Consent for Release of Information

Patient Name: _____ Date of Birth: _____

( ) I hereby authorize the practice of Melville H. Hughes, M.D., P.C. to release the following information from the medical record of the above named patient.

( ) I hereby authorize _____ (name of physician) or his/her staff to release the following information from the medical record of the above named patient.

( ) copy of entire record ( ) all test results ( ) other: _____

I authorize this confidential information to be released to:

( ) Melville H. Hughes, M.D., P.C.
Tania Cohen, PA-C, MPAS
1 Bushwick Rd, Suite D
Poughkeepsie, NY 12603
Ph: (845) 471-5095
Fax: (845) 471-5096

( ) Melville H. Hughes, M.D., P.C.
Tania Cohen, PA-C, MPAS
7 Pine Woods Rd, Suite 5
Hyde Park, NY 12538
Ph: (845) 229-3376
Fax: (845) 229-3378

The information is being requested for the following purpose(s):
( ) Continued medical care
( ) Insurance matters
( ) Other

The authorization shall remain in effect from the date signed below until rescinded.

I understand that:
I may inspect or copy the protected health information to be used or disclosed.
I may revoke this authorization by writing to your office at an above address.
Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Signature: _____ Date of Consent: _____

Relationship to Patient: _____ Printed Name (if app.) _____
(if release is signed by other, parent/guardian of patient)

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