Dr. Bonnie Skakel
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Authorization for Release of Confidential Information

Patient name: ____

Former name (if applicable): ____

Address: ____

City: ______________________________ State: __________ Zip: __________

SS#: ____________________________ Date of Birth: ___________________

I hereby request and authorize:____
(name of previous doctor/ hospital)

Address:____

Phone:____________________Fax:______________________________

to disclose the following information:

- ☐ All Lab Work
- ☐ Other: ____

to:

- ☐ Dr. Bonnie Skakel

date/year approximately of lab work/other ____

for the purposes of ____

I release my previous provider from any legal responsibility or liability that may arise from the release of this information. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Once my records have been disclosed, the recipient may re-disclose it in some instances. Privacy laws may no longer protect the information. This consent expires ninety (90) days after the date on which this form is signed.

I further acknowledge that this information was explained to me and is given voluntarily and of my own free will.

Signed : ____ Dated: ________________________

Special Note : I understand that the information disclosed may contain matter that is protected by Federal and State laws, including but not limited to diagnosis and/or treatment for: sexually transmitted diseases including HIV testing, substance abuse, and mental health conditions. I specifically consent to the release and disclosure of this information.

Signed: ____ Dated:__________