Patient Name:_____ **Date of Birth:**_____

Vilma Junio, MD, PLLC
Patient Authorization to Use or Disclose Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable protected health information as directed on this form to the person(s)/organization listed below. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be subject to redisclosure by the recipient.

Who will be disclosing the information? Name of person(s) organization and address authorized to make the requested use or disclosure of the patient's protected health information:

Vilma Junio, MD
101 West Utica Street, Suite B
Oswego, New York, 13126
Phone: (315) 342 4217 Fax: (315) 342 7205
Name of person(s)/ organization and address authorized to receive the patient's health information:
Physician/Organization:_____
Address:_____
_____
Phone No.:_____

Description of the information to be used or disclosed (check all that apply):
( ) Medical Data/Information as related to specific condition.
Specific condition(s):_____
Specific professional service(s):_____
Specific medication(s):_____
( ) Other:_____
( ) The entire medical record.
Purpose of information:
( ) Transfer of medical care
( ) Other:_____ _____

I understand that I retain the right to revoke this authorization at any time, in writing. The written revocation must include:
The patient's name, date of birth, and address
The effective date of this authorization, and recipients of the protected health information according to this authorization.
The patient's desire to revoke this authorization, the date of revocation,, and the patient's signature.

The authorization shall expire one year from signature date, unless otherwise specified.

I understand that Dr. Vilma Junio will not condition my treatment on whether I provide authorization for the requested use of disclosure if to do so will be prohibited by federal or state law. If authorization is to be used for Dr. Vilma Junio's own use, I retain the right to inspect and copy the information to be used or disclosed.
I fully understand and accept the terms of this authorization:

_____ _____
Signature of Patient or Patient's Representative *Date*

_____ _____
Printed Name of Patient's Representative *Relationship to Patient*

_____
Address: Street Apt. # City State Zip Phone No.

Patient Name:_____ **Date of Birth:**_____

Vilma Junio, MD, PLLC

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Physician/Organization:_____
Address:_____
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Phone No.:_____

Name of person(s)/ organization and address authorized to receive the patient's health information:
Vilma Junio, MD
101 West Utica Street, Suite B
Oswego, New York, 13126
Phone: (315) 342 4217 Fax: (315) 342 7205

Description of the information to be used or disclosed (check all that apply):
( ) Medical Data/Information as related to specific condition.
Specific condition(s):_____
Specific professional service(s):_____
Specific medication(s):_____
( ) Problem Lists, Growth Chart, Immunization Record, Last Physical and Last Patient's Visit Notes, Consultations, Most Recent Laboratory Results and Radiological Imaging
( ) The entire medical record.
( ) Other_____
Purpose of information:
( ) Transfer of medical care
( ) Other:_____

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The patient's name, date of birth, and address
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