Authorization for Release of Medical Information

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

RECORDS REQUESTED FROM MY PHYSICIAN
Physicians Name_____
Address_____
City, State, Zip_____

I authorize release of information for the following reason:
_____Consult/Second Opinion _____Relocating Out of Town

_____Selecting a New Physician _____Other

RECORDS TO BE RELEASED TO
Physicians Name_____
Address_____
City, State, Zip_____

I direct that all information obtained in association with the release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific written authorization. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in the space_____. I understand that except to the extent that action has been taken based on my authorization I may withdraw this authorization at any time by written notification to the parties involved.

It is my desire that only the information indicated below be released as a result of this authorization.

_____Complete Chart Other_____

Patient Rights

The patient has the right to revoke this authorization and terminate further disclosure of health information.
The patient has the right to review the health information used or disclosed under this authorization.
The patient has the right to decline this authorization. Treatment will not be denied unless the authorization was for research related treatment and information, disclosure, or the treatment is solely for the purpose of disclosing to another individual or business.

Information that is disclosed under this authorization may be further disclosed by the recipient of the health information. Bharatkumar Patel, MD cannot guarantee the further safeguarding of the health information after disclosure.

_____ _____
Patient or Guardian Signature Date

_____ _____
Print Patient Name Date of Birth

_____
Patient Social Security Number