Desai Medical Center
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Request Release From

Physician's LN		**Physician's FN**	
Name of Practice			
Phone#		**Fax#**	
Street Address		**City, State, Zip Code**	

Patient Information

Last Name		**First Name**	
Date of Birth		**SSN**	
Street Address		**City, State, Zip Code**	

I hereby authorize you to release to Desai Medical Center a copy of my medical records to be used for continuing medical care. I understand that the Protected Health Information may be re-disclosed by the recipient and thus, will no longer be protected under Federal Privacy Regulation.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization. I understand that I can revoke this authorization in writing at any time. I understand that revoking this authorization will not affect any disclosures made or actions taken prior to the receipt of revocation.

I understand that I am entitled to a copy of this authorization and the copy may be utilized with the same effectiveness as the original.

This authorization will expire one year from the date of the signature below.

_____ _____

Signature Date

Records Authorized to be Released

Dates to Release:					Lab results		List of Procedures
	Demographics		Diagnosis List		Radiology Reports		Hospitalization Records
	History & Physical		Consultation Reports		Procedure Reports		List of Past Physicians
	Follow-up Visit Notes		Medication List		Pathology Reports		Other: