

MEDICAL RECORDS RELEASE

Patient Name: _____	SSN: _____ DOB: _____
Information Requested From: Name: _____ Address: _____ <hr/> Phone: _____ Fax: _____	Recipient of Records: Parveen S. Vahora, M.D PA 9332 State Road 54 Suite 403 Trinity, FL 34655 Phone: (727) 376-1536 Fax: (727) 376-1539

INFORMATION TO BE DISCLOSED:

DESCRIPTION:	DESCRIPTION:	SUPER CONFIDENTIAL RECORDS:
<input type="checkbox"/> Medical Records for Continuity of Care <input type="checkbox"/> Physician Dictated Notes <input type="checkbox"/> Office Notes & Reports <input type="checkbox"/> Clinician office chart notes <input type="checkbox"/> Billing statements	<input type="checkbox"/> Most recent one year history <input type="checkbox"/> Entire Medical Record (all info) <input type="checkbox"/> Transcribed hospital reports <input type="checkbox"/> Diagnostic imaging/X-Rays reports <input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Alcohol and Drug therapy notes <input type="checkbox"/> Communicable disease (HIV, HBV) <input type="checkbox"/> Psychotherapy office notes <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____

PLEASE SEND THE FOLLOWING Last 3 Progress Notes, Recent Labs, X-Rays, EKG, Mammogram & Testing, Consultations, Medication Sheets, & Summary of Care

Purpose of Disclosure:		
<input type="checkbox"/> Ongoing Continued Medical Care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Disability
<input type="checkbox"/> Patient's Request	<input type="checkbox"/> Legal follow up	<input type="checkbox"/> Personal Information

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. 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.

I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), Prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

PRINT PATIENT'S NAME

DATE

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

DATE

PRINT NAME OF LEGAL REPRESENTATIVE (If applicable)

RELATIONSHIP TO PATIENT