MEDICAL RECORDS RELEASE

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

INFORMATION TO BE DISCLOSED:

DESCRIPTION:	DESCRIPTION:	SUPER CONFIDENTIAL RECORDS:
□ Medical Records for Continuity of Care □ Physician Dictated Notes □ Office Notes & Reports □ Clinician office chart notes □ Billing statements	□ Most recent one year history □ Entire Medical Record (all info) □ Transcribed hospital reports □ Diagnostic imaging/X-Rays reports □ Laboratory Reports	□ Alcohol and Drug therapy notes □ Communicable disease (HIV, HBV) □ Psychotherapy office notes □ Other: _____ □ 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:		
□ Ongoing Continued Medical Care	□ Insurance	□ Disability
□ Patient's Request	□ Legal follow up	□ 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 REPRESENATIVE DATE

_____ _____

PRINT NAME OF LEGAL REPRESENTATIVE (If applicable) RELATIONSHIP TO PATIENT