Dr. Satish Patel, M.D.

Confidential Patient Authorization for Release of Information

Patient Name______________________________ Phone__________________ D/O/B____________

Address________________________________ City____________ State___________ Zip__________

Patient authorizes the following provider to disclose information specifically described below:

Physician: Dr. Satish Patel Phone: 727-849-0222 Fax: 727-847-7685
Address: 5340 Gulf drive, Suite 105 City: New Port Richey State: FL Zip: 34652

By checking any box below, Patient acknowledges that such information is being authorized by patient for disclosure to the recipient named below. Patient further acknowledges that such information may be re-disclosed by such recipient and may no longer be protected by federal privacy regulations.

☐HIV/AIDS ☐Mental Health ☐Substance Abuse ☐Sexually Transmitted Disease ☐Pregnancy (If a minor)

Information to be used / disclosed is specifically described below:

☐Office Notes: Date(s) of Service: ____

☐Diagnostics: Type of report(s):___________________________ Date of Service: ____________________

☐Lab: Date(s) of Service: ___________________________________

☐other (Please specify):_____________________________ Date of Service: _____________________

Purpose of Disclosure

☐Legal ☐Insurance ☐Personal Use ☐Continued Medical care ☐ Other(specify) __________

This information may be disclosed to and used by the following individual or organization

☐Release to Patient ☐Release to: ____

Address: ____

City: __________________ **State:** ____________ **Zip:** ___________

This Authorization shall expire one (1) year from the date of signature unless otherwise noted here: ____________

Important; by signing below, patient understands that this authorization for release of medical records ("Authorization") shall only include medical records dated prior to and including the date of this authorization. Patient understands that this authorization shall only include medical records originated through Dr. Satish Patel (the "Practice") unless otherwise specifically requested. Patient further understands that this authorization is voluntary and patient may refuse to sign. If patient refuses to sign, patient's refusal will not affect patient's ability to obtain treatment from the practice. Patient understands that this authorization may be revoked at any time by notifying the Practice Manager 5340 Gulf Drive Suite 105, new Port Richey FL 34652. However, revocation shall not be valid to the extent the practice has taken action in reliance on this authorization or to the extent this authorization is executed as a condition for obtaining insurance coverage. Patient understands that the practice shall not condition treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether patient provides authorization for the requested use or disclosure.

____ ______________________________

Patient / Authorized Representative Signature Date

Request Completed By: ________________________________ Date: ____________________________

By: ☐Mail ☐ Fax ☐Pick-up ☐Copy Service