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_____ Phone: _____ Fax: _____
Address: _____ City: _____ State:_____ Zip: _____

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: Dr. Satish Patel**
Address: 5340 Gulf Drive Suite 105
City: New Port Richey State: Florida Zip: 34652

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