AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient Name _____
Address:_____
DOB:_____SocialSecurity_____(optional)
I authorize the following individual or organization to disclose the above named individual's health
BHAGWAT PATEL M.D., P.A Address: 1250 CREEKWAY DR., # 100 SUGAR LAND, TX 77479.
The information may be disclosed TO OR FROM the following individual or organization _____
Address:
_____
PHONE:
_____FAX:_____
This information may be disclosed and used by the individual or organization:
For the purpose of: _____
Please release the following: {Note: list not required by HIPAA}
___Entire Record
Or: ___Problem List ___X-Ray/Imaging Reports-from (date)_____ to (date)_____
___Progress Notes ___X-Ray Films
___History/Physical Exam ___Laboratory Results-from (date)_____to (date)_____
___Medication List ___EKG Reports
___Immunization Record ___Genetic Testing Information
___List of Allergies ___Other Diagnostic Reports (Specify)_____
___Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or
mental health services, and treatment for alcohol and drug abuse.

___Yes, I consent to the release of this information. ___ No, I do not consent to the release of this information.
I understand that the information released is for the specific purpose stated above. Any other use of this information without thewritten consent of the patient is prohibited.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following

_____
Signature of Patient or Legal Representative Date
_____ _____
Relationship to Patient (If Legal Representative) Witness
Date request completed_____ # pages copied_____ Reviewed only_____
Charges $_____ Cash_____ Check #_____ Initials_____

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I shouldcontact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
DATE:_____.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact__DR BHAGWAT PATEL.