MEDICAL RECORDS RELEASE AUTHORIZATION

TO: _____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MEDICAL, MENTAL, ALCOHOL AND/OR DRUG ABUSE, HIV (HUMAN IMMUNODEFICIENCY VIRUS) TESTING, EATING DISORDERS OR ANY OTHER MEDICAL INFORMATION OF SENSITIVE NATURE TO THE FOLLOWING ORGANIZATION:

Navnit U. Patel M.D. PA
Internal Medicine & Pediatrics
2254 US Hwy 19 N
Holiday, Florida 34691

Office Number: (727) 943-7710 ***Fax Number: (727) 944-3410***

The type of information to be used or disclosed:

- ○ History and Physical
- ○ Discharge Summary
- ○ Progress Notes/Clinical Assessment
- ○ Laboratory Results
- ○ Treatment Plan
- ○ X-Rays
- ○ Immunization Records
- ○ Medication Records
- ○ Psychiatric Evaluation
- ○ Psychotherapy Note

I understand that I have the right to revoke this authorization in writing to the facility listed above. I understand that the revocation will not apply to information that has already been release 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

PATIENT NAME: _____ DATE OF BIRTH_____

PATIENT ADDRESS: _____

Telephone #: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

DATE SIGNED: _____WITNESS SIGNATURE _____