AUTHORIZATION TO RELEASE AND OBTAIN FROM PROVIDER

I hereby give my permission to this provider organization to release or to request personal health information contained in my medical records to the organization listed.

Patient name: _____

Patient address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Provider requesting records:

Provider: PRACHI GANDHI, DO PA

1027 Town Center Drive

Orange City, Florida 32763 Fax: 386 218 0201

To release to/obtain from:

Provider: _____

Address: _____

_____

Phone #: _____ Fax #: _____

I understand that this authorization will allow this provider organization and its affiliates to use or disclose my protected health information**. I understand that my medical record may contain sensitive information such as mental health, HIV, AIDS, substance use disorders, sexual abuse and/or other related conditions.** I understand that those records are classified as privileged and confidential and cannot be released to me or those designat4ed by me or my legal guardian without an express and informed written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative as provided by state or federal law.

_____

Signature Date

AUTHORIZATION TO RELEASE AND OBTAIN FROM PROVIDER

Patient Name: _____ Date of Birth: _____

I understand that this authorization will allow this provider organization and its affiliates to use or disclose my protected health information. **I understand that my medical record may contain sensitive information such as mental health, HIV, AIDS, substance use disorders, sexual abuse and/or other related conditions.** I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an express and informed written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative as provided by state or federal law.

PLEASE SELECT ONLY **ONE** OPTION BELOW:

_____ I authorize release or request all of my medical records including sensitive information such as mental health, HIV, health status or substance use disorders.

_____ I authorize the release of what my doctor deems necessary/as needed.

_____ I authorize only the following dates:

_____

_____

_____ I authorize only the following items of information to be disclosed or released:

_____

_____

Please put a **check mark** beside those items that you **allow** to be disclosed:

_____ Discharge summary

_____ Progress Reports/Notes

_____ Treatment Plans

_____ Social Development History

_____ Labs

_____ X-Rays

_____ Immunizations

_____ Special Studies (EKG, Mammograms, MRI, etc.)

_____ Psychological/psychiatric Evaluation

_____ All of my medical records including sensitive information (such as mental health, HIV, health Status, sexual abuse or substance abuse records)

_____

Signature Date

AUTHORIZATION TO RELEASE AND OBTAIN FROM PROVIDER

Patient Name: _____ DOB: _____

I understand that records sent through unencrypted email pose a security risk but it is my requested method. In addition, … I understand the following:

- I may revoke this authorization at any time by providing written revocation to this facility.
- I understand that a revocation of this authorization will not apply to any actions taken or information released prior to my written revocation.
- I understand that authorizing the disclosure of this information is voluntary. I also understand that treatment, payment or eligibility for services is not based upon signature of this authorization.
- I understand that information used or disclosed prior to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal privacy laws.
- I understand that this provider organization will release only the minimum amount of information necessary to fulfill the request.
- I understand that this authorization is valid for one (1) calendar year from date of signature unless I send a written request to the facility to revoke this request.
- I understand that information released will be to provide continuity of care and could include sensitive information (such as mental health, HIV, health status, sexual abuse or substance use disorders).

_____

Patients printed name

_____

Signature Date