AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		Phone	

RELEASE TO: (Rajani Medical Group, LLC is the recipient of the records)						
Name	**Rajani Medical Group, LLC** **Attn: Medical Records**			Fax	**727 726 0529 (Please mail if more than 20 pages)**	
Address	**2812 SAINT MARKS DRIVE**					
City/State Zip	City	**DUNEDIN**	State	**FL**	Zip	**34698**

OBTAIN RECORDS FROM: (Who is Releasing the Records)						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

<u>**For the Following Purposes**</u>: Continued Medical Care

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

X	Last 2 years of office notes and reports				
X	Last Colonoscopy Report	X	ALL Diagnostic Imaging	X	Last Eye Exam Report
X	Medication List	X	Transcribed Hospital Reports	X	ALL Laboratory Reports
	Others Listed Here:				

The Following Items Must Be <u>INITIALED</u> to Be Included in the Use And/or Disclosure:

_______ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_______ Mental Health Information and/or Records

_______ Domestic Violence

_______ Genetic Testing Information and/or records

_______ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_______ Other: ____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that <u>**I may revoke this authorization**</u>, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in twelve (12) Months from the Date of Signing or until (Insert Date): ______________________.

Print Patient's Name: ______________________________________ Date: ____________________________

Signature of Patient or Patient's Legal Representative: ____

Print Name of Legal Representative (if applicable): ____

Relationship to patient: ____________________________