

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

For the Following Purposes: 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:

<input checked="" type="checkbox"/>	Last 2 years of office notes and reports				
<input checked="" type="checkbox"/>	Last Colonoscopy Report	<input checked="" type="checkbox"/>	ALL Diagnostic Imaging	<input checked="" type="checkbox"/>	Last Eye Exam Report
<input checked="" type="checkbox"/>	Medication List	<input checked="" type="checkbox"/>	Transcribed Hospital Reports	<input checked="" type="checkbox"/>	ALL Laboratory Reports
	Others Listed Here:				

The Following Items Must Be INITIALED 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 **I may revoke this authorization**, 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: _____