

PARAG B. THAKKAR, MD, SC

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: (First Name) (Middle Initial) (Last Name) Date of Birth:

Address:

Parag B. Thakkar, MD SC is authorized to disclose to / receive from (circle desired choice):

Recipient/Discloser:

Address:

For the Purpose of: (optional)

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

- I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.
I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

I release Parag B. Thakkar, MD SC, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Parag B. Thakkar, MD SC, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ___/___/___ (Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

Patient Signature (Parent's Representative if minor)

Date

Witness Signature

Date

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

- Not satisfied with Provider
Not satisfied with Staff (which staff member?)
Moving out of the area?
Other (Please describe :)