Authorization for release of Medical Records TO / FROM

Excel Primary Care, PLLC
Dr. Meena Venugopal
3303 S. Lindsay Rd. #115, Gilbert, AZ, 85296
Tel: 480-507-0604 Fax: 480-507-0592

Patient Name: _____ DOB: _____

I hereby authorize the release of individually identifiable health information from:

Name of facility/physician: _____

Telephone number: _____

Fax number: _____

Specific Description of the information to be used or disclosed including (if practicable the dates of service(s) related to such information:

Dates of service from: _____to _____
_____ All Records (including substance/drug abuse,communicable,Venereal disease,HIV, Syphilis Etc., Mental Health record, Genetic testing)
____Office Notes (Consultations, Progress notes)
____ Labs
____Diagnostic testing (MRI, CT, X Ray etc.)
____ Other: _____

The above information will be called "Authorized information" throughout the rest of this form.
Right to Revoke: We must receive a written letter stating that you want to revoke the release of medical records

Authorized information will be used for and/or disclosed for the following purposes:
( ) Continuing Medical Care.
( ) At the request of the individual (check box if applicable)
( ) Other (Please list each purpose of the use(s) or disclosure(s) in the space provided.):

- I understand that if the person or entity receiving Authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan or eligibility for benefits.

Signature of patient or Patient's personal representative: _____

Relationship to patient (guardian, parent, etc) _____ Date:_____