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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

PATIENT NAME:_____

DATE OF BIRTH:_____ DAY PHONE:_____ LAST FOUR OF SSN:_____

I Authorize: _____ To Disclose to: Dr. Ankita Ambasht

_____ Fax: 877-669-0236

By initialing the spaces below, I specifically authorize the release of the following medical records, if such exist by fax or mail.

Release the following information:

_____Complete records

_____Laboratory reports

_____X-ray reports

_____EKG reports/Holter/echo

_____Office notes

_____Other (specify):_____

For the purpose of:

_____Continuing care

_____Transfer of care

_____Other (specify):_____

I understand I have the right to revoke this authorization at any time and must do so in writing and this does not apply to the information which has already been released as a result of this authorization. I understand that this revocation will not apply to my insurance companies and payors when the law provides my insurer with the right to contest a claim or process a claim under my policy. Unless otherwise revoked this authorization will expire on_____. If I fail to specify an expiration date, this authorization will expire 90 days from the date it was signed. I understand that disclosure of health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure and may no longer be protected by the federal confidentiality laws. If I have any questions about this disclosure, I can contact Dr. Ambasht at 770-6200.

I understand that the first copy of my records for the purpose of continuing care/or transfer of care is given free of charge. For any additional copies there will be a charge of $55.00 or more depending on the volume of the chart. For legal request there is always a charge depending on the volume of the chart.

PATIENT/LEGAL GUARDIAN SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

FOR OFFICE USE ONLY

NAME OF EMPLOYEE who processed the request_____ Date request processed_____