Authorization of Medical Record

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION _____ Name of Patient Birth Date of Patient _____ Address

I authorize my records to be released from: I authorize my records to be released to:

Express Family clinic, Dr. Pradeep Parihar and Dr. Sunil Modi MD 940 Ridgeview Dr Ste 150, Allen, TX 75013 Tel-972-672-4121 and fax- 972-905-4690. Information to be released:

___ Medical History, Examination Reports

___ Surgical Reports

___ Treatment or Tests

___ Hospital Records including Reports

___ X-ray Reports

___ Development Disabilities

___ Laboratory Reports

___ Prescriptions

___ HIV Test Result *

___ Consultations

___ Mental Health

___ Allergy Records

___ Sexually Transmitted Disease

___ Drug Abuse

___ Alcoholism ___ Other (Please specify) _____ * A listing of the statutory exceptions to release of HIV test results without consent is available Purpose for Need of Disclosure At the request of the individual understand that the health information disclosed as a result of this authorization may no

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longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization. I understand that I have the right to: Receive Copy of This Authorization. Refuse to Sign This Authorization and that treatment, payment, enrollment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my singing this authorization. Revoke This Authorization, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization. This authorization will remain in effect until the following date(s):

_____

Signature of Patient (or Patient Representative)

Date

If signed by Legal Representative: _____Relationship to Patient ---------- Date