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Authorization to Release or Obtain Health Care Information

Patient Name:	Birth Date:
Address:	Phone:

I hereby authorize Desai Health providers to request or release the medical information about me indicated below to the following person or entity:

Provider Name:	
Phone:	Fax:
Documents Needed:	

Purpose of Release:

- ❑ Continued Care
- ❑ Collaboration
- ❑ Requesting Specific Records
- ❑ Insurance
- ❑ Disability
- ❑ Legal
- ❑ Personal
- ❑ Other:_____

If for continued care, records are needed for doctor's appointment on: _____

-I am aware that my records may contain information related to mental health, substance abuse and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.
-I understand that this authorization will expire in one (1) year, but I may revoke it at any time in writing. I understand that any such revocation will not apply to any information already released under this Authorization.

By signing below, I authorize Desai Health providers to release or obtain medical information about me as described above.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Relationship to Patient (if applicable)