DESAI HEALTH

8823 San Jose Blvd., Ste. 301, Jacksonville, FL 32217
PH: (904) 638-8164 FAX: (704) 270-6207
www.desaihealth.com

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH CARE INFORMATION

Patient Name:	Date of Birth:
Address:	Phone:

I hereby authorize Desai Health providers to ___**request** or ___**release** information about me as indicated below to the following person(s) or entity (full name/address/phone or fax must be provided):

Name:	Address:
Phone:	Fax:
Records Requested: _____ ALL _____Verbal Exchange only _____ specific records: _____	
Purpose of Release: _____Continued Care/Collaboration _____Legal _____Personal _____Other: _____	

-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 upon written request. 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 information about me as described above.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient (if applicable)