AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	Date of Birth:
Address:	Phone:

Release Medical Records FROM:	**Disclose Medical Records TO:**
Name: ____	Name: ____
Address: ______________________________________	Address: ______________________________________
City/State/Zip: _________________________________	City/State/Zip: _________________________________
Phone: _______________________________________	Phone: _______________________________________

THE FOLLOWING PROTECTED HEALTH INFORMATION MAY BE DISCOSED (describe in detail):

Purpose of Disclosure (please specify):
_____ Continued Care/Collaboration _____ Legal _____Personal _____Other: ____________________

Expiration Date or Event (if left blank, this Authorization automatically expires one (1) year from the date signed):

I understand that I may revoke this Authorization at any time by notifying Desai Health in writing, and further understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
I understand the information disclosed may be subject to re-disclosure and no longer protected by federal privacy regulations.
I understand that I may refuse to sign this Authorization and that if I do not sign this form, my health care will not be affected.
Fees: I understand that there may be costs associated with this request in compliance with State and Federal Copying laws.

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

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Relationship to Patient (if applicable)