AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.
Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol /substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize the office of
Dr Niti Vaid
Tel: 818-707-0290 Fax 818-707-0291

To release information regarding my medical history, illness or injury, progress notes, consultations, lab reports, imaging reports, vaccinations, prescriptions, treatment, diagnosis or prognosis, correspondence and/or any other medical records by means of mail, fax or other electronic methods if applicable

to:

_____

_____
(Insert doctor or facility name, phone, fax)

The medical information/records will be used for continuity of medical care.

This authorization is for the release of:

[Initial] Any and all records, including specific release of the following records if present:
Drug/Alcohol/Substance Abuse, Tests for antibodies to HIV,
HIV Diagnosis/Treatment, Psychiatric/Mental Health

[Initial] Specific records only: _____

DURATION: This authorization shall be effective immediately and remain in effect until 1 year

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another Authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of the authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization. This authorization can be revoked at any time by notifying us in writing.

_____ _____
Signature of patient or legal/personal representative Relationship if other than patient

_____ _____
Patient's Name (PRINT) Today's Date

_____
Patient's Date of Birth