

HEMAL J SHAH, MD PC

Authorization To Disclose Health Information

I hereby authorize Hemal J Shah, MD PC to release and transfer to:

(Doctor, Hospital, Attorney, etc.)

Street Address

City/State

Zip Code

the following information on:

(Patient's Name)

Birth Date

Social Security Number

SPECIFY INFORMATION:

The above information is released for the following purpose and that purpose only.

Other uses are prohibited

I understand that the specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization will expire ninety (90) days from the date of signature.

I authorize faxing the Information to be disclosed to the requesting party. Yes No

I have read and understand this consent and I have signed It voluntarily and of my own free will.

Signature of Patient (or legal representative)

Witness

Relationship to patient (if representative)

Witness

Date

Date

IF INFORMATION IS RELEASED TO PATIENT:

I understand that my medical record may contain reports, test result and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the Information contained in these entries. I will not hold Hemal J Shah, MD PC liable for any misinterpretation of the Information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Witness