AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(PLEASE PRINT OR TYPE)

Patient's Full Name: _____

Date of Birth: _____

Social Security Number: _____

I, the undersigned, hereby authorize_____
_____

To release my medical records and diagnostic reports to:

Vidhya Subramanian M.D., P.A.
Endocrinologist
16659 Southwest Fwy, Ste 205
Sugar Land, TX. 77479
Phone: (832) 532-7514
Fax: (832)- 532-7801

The above information is released for the following purpose (s): _____

I understand that this authorization is valid for 90 days after the date of my signature.
I have the right to revoke this authorization at any time with the understanding that all or part of this information may have been used in good faith to the revocation, I understand that this authorization authorized the release of all medical records including, but not limited to limited to records concerning Psychiatric, Drug, or Alcohol abuse and communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2, may protect the use of this information. The information provided is confidential and any re-disclosure by the recipient is prohibited without written consent.

Patient's signature: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____
Witness Signature: _____ Date: _____