

AUTHORIZATION FOR RELEASE OF INFORMATION

ATTN: PLEASE MAIL RECORDS OVER 20 PAGES

PATIENT NAME: _____ DATE OF BIRTH: _____

SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DAY PHONE _____ CELL PHONE _____ EVENING PHONE _____

I HEREBY AUTHORIZE _____

(Please put your FORMER Doctor's office and/or medical facility name above)

TO RELEASE INFORMATION FROM MY MEDICAL RECORD AS INDICATED BELOW TO:

DR. PARDEEP SHARMA

117 N Hickory Ave, Suite 200, COOKEVILLE, TN 38501

(931) 646-0880 – PHONE

(866) 380-6439 – FAX

INFORMATION TO BE RELEASE:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> HISTORY AND PHYSICAL EXAM | <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> LAB REPORTS |
| <input type="checkbox"/> XRAY REPORTS | <input type="checkbox"/> MRI, CT, ULTRASOUND | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> ENTIRE CHART | | |

I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:

- SUBSTANCE ABUSE (INCLUDING ALCOHOL)
- MENTAL HEALTH (INCLUDING PSYCHOTHERAPY NOTES)
- HIV RELATED INFORMATION (AIDS RELATED TESTING)

SIGNATURE OF PATIENT

DATE

PURPOSE OF DISCLOSURE:

- | | | |
|---|---|---|
| <input type="checkbox"/> CHANGING PHYSICIAN | <input type="checkbox"/> LEGAL | <input type="checkbox"/> CONSULTATION/2 ND OPINION |
| <input type="checkbox"/> CONTINUING CARE | <input type="checkbox"/> SCHOOL | <input type="checkbox"/> INSURANCE |
| <input type="checkbox"/> WORKERS COMPENSATION | <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ | |

1. I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE ON _____.
2. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING DR. SHARMA'S OFFICE, IN WRITING. IT WILL BE EFFECTIVE ON THE DATE NOTIFIED EXCEPT TO THE EXTENT ACTION HAS ALREADY BEEN TAKEN.
3. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE