Mina G Patel, MD
1200 Brooks Lane
Clairton PA 15025
Phone: 412-405-8475
Fax: 412-278-1399

Authorization For Release of Medical Information

Patient(s) Name _____ DOB: _____

Address: _____

Phone: _____

****

I hereby request and authorize the following physician/medical facility: _____

_____to release all medical information pertaining to the above mentioned chart to:

Physician/Facility name: _____

Address: _____

For the purpose of: _____

****

I understand that this medical record may contain information regarding treatment of alcohol/substance abuse, HIV testing results, diagnosis of AIDS or mental health information.

_____ I do give consent for this information to be released.

_____I do not give consent for this information to be released.

I understand that:

***This authorization will be used for the purpose stated above.**
***Information released as a result of the Authorization may be re-disclosed by the recipient, therefore, as a result of the re-disclosure; the information may not be protected by law.**
*** I may revoke this consent at any time provided a written request be presented to the physician/facility where the authorization originated. Request to revoke the authorization will not include information that has already been used or disclosed based on the previous authorizations.**
***This authorization expires 6 months from the date of the signature below unless otherwise stated**.

_____ _____

Signature (Parent/Guardian if patient a minor) **Date**

Relationship to Patient: _____