

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(PRINT Patient's Full Name)

Birth Date (Mo/Day/Yr)

(Street Address)

Social Security Number

(City, State, Zip Code)

Home Phone

(PARENT OR GUARDIAN) _____

At the request of the individual, I _____, do hereby
authorize _____ to release:

- | | | |
|---|---|--|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> EMERGENCY REPORTS |
| <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> LABORATORY REPORTS | <input type="checkbox"/> ENTIRE CHART |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> OPERATIVE NOTES | | |

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) of HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO: **Dr. Naga Chigurupati**
2110 Hartford Road, Suite A
Hampton, VA 23666
Phone: (757) 224-5682
Fax: (757) 663-5682

PURPOSE OF DISCLOSURE:

REFERRAL TO SPECIALISTS

OTHER (SPECIFY): _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

SIGNATURE OF INDIVIDUAL OR GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE

DATE

PLEASE PROVIDE CURRENT TELEPHONE NUMBER IN THE EVENT WE NEED TO CONTACT YOU: _____