HARSHAD PATEL, MD, PC

Child, Adolescent and Adult Psychiatry

Authorization to exchange/disclose Health Care Information

RE: Patient: _____ Date: _____

Date of Birth: _____ SSN: _____

I request and authorize HARSHAD PATEL MD PC to **exchange/release/receive** the health care information described below to and from:

(1)_____ (2) _____

_____ _____

for the purpose of collateral or _____ for the purpose of collateral or _____

(3)_____ (4) _____

_____ _____

for the purpose of_____ for the purpose of _____

The following information is requested: [ ] All Medical / psychiatric / alcohol / substance related information
[ ] _____(Please specify)

Authorization expires: __/__/____or if date is not written then this consent extends throughout the period necessary to complete all transactions related to services provided to me.

NOTE: - This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to HARSHAD PATEL MD PC.

I understand that Dr. HARSHAD PATEL MD PC may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

The exchange/use or disclosure requested under this authorization will result in direct or indirect remuneration to the HARSHAD PATEL MD PC from a third party.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

By signing this authorization, patient / authorized representative agrees to hold Dr. Harshad Patel harmless for release / request of information prior to revocation.

_____ _____

Signature of Patient or Authorized Representative Date of Authorization

_____

Witness Signature

4994 Lower Roswell Road, Suite 29, Marietta, Georgia 30068, Ph:(770) 977-2987 Fax: 678 236 6041