PRISAT, PA.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the release of my medical records for the continuity of my care as needed by the providers of PRISAT, PA. I understand that the records will be kept confidential as per the HIPPA regulations and only be used as necessary for the management and co-ordination of my health care.

To :

_____

_____

_____

_____

Please release my healthcare information to,

PRITA MADKAIKER, MD.
3685 Crown Point Court,
Jacksonville, Fl 32257.
Ph 292-4129
Fax 268-3293/ 880-8840

Please release the following information of:

_____ History/Physical _____ Last 3 Progress Notes.

_____ Laboratory Tests _____ Radiology / Diagnostic Testing.

_____ HIV results _____ Hospitalization records.

_____ Mental Health records _____ Consultation / Specialist reports.

_____ Medication History _____ Drug / Etoh history

_____ Other. Specified _____

Patient's Name: _____ **DOB** _____ **SSNo** _____

Patient Signature _____ Date _____

Legal/ Guardian/ POA _____ Date _____

Reason patient not able to sign_____

Witness _____ Date _____