REENA R. PATEL MD INC

1730 Huntington Drive, Ste #203
South Pasadena, CA 91030
Phone: 626-765-7852 Fax: 626-606-3952
E-Mail: office@ReenaMD.com
Web: www.ReenaMD.com

Medical Release Form

HIPAA Compliant Authorization

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. (Parts 160 and 164)

I authorize the following: ☐ Primary ☐ Specialist ☐ Hospital/UC/ER _____

to use and disclose the protected health information described below to Reena R. Patel, MD.

Fax number (_____)_____

This protected health information includes information contained in my medical records, which may include, and may not be limited to my medical history, laboratory results, radiology results, and my physician's diagnosis for treatment. I understand the information to be released or disclosed may include information relating sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychiatric disorders/mental health and alcohol and drug abuse.

I authorize the release or disclosure of this type of information.

This authorization shall be in full force and effect for 180 days at which time this Authorization for Use and Disclosure of Protected Health Information expires.

The person I authorize to receive this information may use this medical information as I may direct for medical treatment, consultation, billing, claims payment, or other purposes.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditions on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

PLEASE FAX: To the office of REENA R PATEL MD INC at FAX #: 626-606-3952

☐ All Medical Records ☐ Immunizations ☐ Imaging ☐ Labs ☐ Other _____

_____ _____
Print Name Date of Birth

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Name and Relationship of Legally Authorized Representative to Patient Date