AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

NAME OF PATIENT _____ **DATE OF BIRTH** _____

AUTHORIZES: _____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: Keshav Narain, MD – South Bay Retina
455 O'Connor Dr #310, San Jose, CA 95128
Phone: (408) 294-3534 | Fax: (408) 294-3214

This authorization is:

[ ] Unlimited (all records, including Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

__ Drug/Alcohol/Substance Abuse	__ HIV Diagnosis/Treatment	__ Psychiatric/Mental Health
__ Genetic Information	__ Tests for Antibodies to HIV	__ Clinical Records
__ Eye Records	__ Visual Fields	__ Allergy Records
__ Office Notes	__ X-ray/film	__Lab Reports
__ Electrocardiograms	__Photographs	__ Other

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date