

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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Drug/Alcohol/Substance Abuse | <input type="checkbox"/> HIV Diagnosis/Treatment | <input type="checkbox"/> Psychiatric/Mental Health |
| <input type="checkbox"/> Genetic Information | <input type="checkbox"/> Tests for Antibodies to HIV | <input type="checkbox"/> Clinical Records |
| <input type="checkbox"/> Eye Records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> X-ray/film | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Electrocardiograms | <input type="checkbox"/> Photographs | <input type="checkbox"/> 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