ADULT AND PEDIATRIC CLINIC, P.C.
Shama Mittal, M.D.
14816 Physicians Lane, Suite 152, Rockville, MD 20850

Phone: (240) 453-0000 EMR Email: mittalmedical@direct.practicefusion.com

Authorization for Release of Patient Information

Patient Name_____ Date of Birth_____

I hereby authorize _____
Name of Previous Doctor or Provider Address

_____
City State Zip

Telephone Number_____ Fax Number_____

to disclose the above named individual's health information as described below:

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

___Immunization record ___Most recent history and physical
___Laboratory reports ___Consultations
___Radiology/Imaging reports ___Progress notes ___Entire medical record
___Other_____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug(substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization:

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Description of the purpose of the use and/or disclosure:

___Continuing Care ___Second Opinion ___Consultation
___Other: Please describe: _____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient or Patient's Representative

_____
Relationship to Patient