Natesan Medical Group
Vel Natesan MD, PA

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Salisbury, MD 21804
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• PLEASE PRINT •

Authorization for Release of Medical Records

Patient's Name_____ DOB_____ SS#_____

Address_____ Phone_____

1. Persons or group of persons authorized to use/disclose this information and purpose:

☐ Vel Natesan, MD, PA or Natesan Medical Group

☐ _____
Name of physician/provider

_____
Street State Zip

Purpose:
☐ My personal health records
☐ Transferring to another provider
☐ Sharing information with another provider
☐ Other _____
_____

2. Persons or group of persons authorized to receive this information:

☐ Vel Natesan, MD, PA or Natesan Medical Group ☐ Me

☐ _____
Name

_____
Street State Zip Telephone Fax

3. Description of information to be used or disclosed: *(Please mark box with an X)*

☐ Laboratory Reports ☐ Records of health care ☐ Mental Health records ☐ HIV information
☐ Immunization records ☐ X-ray & other images

4. This section must be completed if request for disclosure is made by someone other than the above-named patient:

Purpose for disclosure:

I understand that the person I am authorizing to use/disclose my protected health information may receive compensation for doing so. _____ (patient initials)

I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment or payment or eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. _____ (patient initials)

5. I understand that if the party receiving this information is not a health care provider or health plan subject in the federal privacy regulations that the information described above may be redisclosed and no longer protected by the privacy regulations. _____ (patient's initials)

6. I understand that I may revoke this authorization in writing or any time except to the extent that action on this authorization has not already occurred and that my records are protected under federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Recoreds, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1995 (HIPAA). 45 C.F.R. Pts. 160 and 164. _____ (patient's initials)

7. This authorization becomes effective _____ and will expire on _____
Date *Date*

_____ _____ _____
Patient (or Representative) Signature *Relationship to Patient* *Date*

_____ _____
Witness Signature *Date*