Minesh A. Patel, MD

Primary Care Medicine
404 NW HALL OF FAME DRIVE
Lake City, FL. 32055
Phone 386 754 3627
Fax 386 754 3657

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Physician Name: ___________________________________

Patient Name: _______________________

DOB: _______________________

SS#: _______________________

I, ________________ do herby authorize to release any or all that apply.
Initial each line.

___ Entire Medical Records
___ from ____ to ____ date
___ X-Ray Reports
___ Lab Reports
___ Other

___ Psych / Psychological
___ Adult & Child Abuse info
___ HIV/AIDS Records
___ Drugs/Alcohol Records
___ STD Records
___ TB Records

Release to:
Minesh Patel, MD 404 NW HALL OF FAME DRIVE, Lake City, FL 32055

SIGNED: ______________________________________ DATE: ________
(Signature of patient or legal representative)

____
Witness (Legal Representative's Relationship to patient)