Sweetwater Pulmonary Associates

Sandip Desai, M.D.

Authorization for Release of Healthcare information

Patient Name: _____ DOB: _____

I hereby authorize the transfer/receipt of the following healthcare information:

To: _____ From: _____

_____ _____

Phone: _____ Phone_____

	Discharge Summary
	History & Physical exam
	Progress Notes
	Consultation Reports
	Operative/ procedure Reports

	Psychiatric Assessment
	Medication Record
	Psychosocial History
	Psychological Report
	Treatment Plan

	Immunization Record
	Imaging/ Radiology Reports
	Entire Record
	Laboratory Reports
	Others _____

Others (Specify)

_____

_____

Purpose of Disclosure:

- Continuing Patient Care
- Other _____

I understand that specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/ psychiatric related illnesses or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand this consent can be revoked at any time except to the extent that disclosure made in good Faith has already occurred in reliance on this consent. The revocation must be writing and delivered to the Dr. Sandip Desai Office Medical Record Department.It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE

_____ **or** _____

(Signature of Patient) (DATE) (Signature of Patient representative) (DATE)

Sugar Land, TX 77479 Phone: 832- 255-6632 Fax: 832-255-6633