Authorization for Release of Medical Information

I, _____ authorize
(Patient's Name - Please Print)

Swati Mungekar , M.D.
15899 Los Gatos Almaden Blvd, Suite 9
Los Gatos, CA 95032
Phone: (408) 358-3685 Fax: (408) 358-3645

to release information from the medical record of:

_

_____	_____	_____
Patient Name	Birth Date	Social Security No.

to _____
(Receiving Physician/Facility)

Phone: _____ Fax: _____

Dates Requested : From _____ To: _____

Information to be released: (Reports may include information on drug / alcohol / psychological / HIV or communicable disease treatment.)

- ☐ History & Physical
- ☐ Consultations
- ☐ HIV/AIDS
- ☐ Progress Notes
- ☐ Laboratory
- ☐ Radiology/MRI/CT
- ☐ EKG
- ☐ Other _____

Purpose for release of information:

- ☐ Personal Use
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Continuing Medical Care
- ☐ Social Security/ Disability
- ☐ Other _____

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/ state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

Signature of Patient or Legal Guardian: **X** _____

Date: _____