Tampa Bay Neurology, Inc

Bharatkumar Patel, MD
8370 W. Hillsborough Ave. Suite 103, Tampa, FL, 33615
Ph: 813-336-3337 Fax: 813-336-3338

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, date of birth ____/____/_____, hereby request and authorize:

_____
(Name and address of provider or facility releasing the records)

To release my PHI (Protected Health Information)/Medical Records Specified:
□ All medical records
□ Other (Specify by type of record): _____
_____
□ I understand that certain information cannot be released without special authorization as required by state or federal law. By initialing the line below, I authorize the release of the following protected or sensitive information:
* **(INITIALS) _____** Any and all Information regarding patient's diagnosis and treatment for HIV, AIDS, sexually transmitted diseases, mental health, alcohol and or drug abuse.

From the time: ___/____/_____ through ___/____/_____
For purpose of:
□ Continuing to receive medical care
□ Information for insurance company
□ Legal
□ Personal
□ Other (Specify): _____

These records may be provided to:

Tampa Bay Neurology, Inc
Bharatkumar Patel, MD
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Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time except to the extent the action has been taken prior to revocation.

Patient Name: _____ DOB: _____ Date: _____

Signature of the Patient or Legal Guardian/Representative: _____