RELEASE OF RECORDS FROM SANJAY GHOSH PHD MD

Informed Consent for Disclosure of Healthcare Information

_____ _____

Patient Name Date of Birth

Street Address_____ City _____

State _____ Zip Code _____ Phone No _____

INFORMATION to be RELEASED:

— Clinical Records
— Other (Specify)
— _____

RELEASE RECORDS TO:

_____

Address _____

Fax: _____ Phone: _____

I understand that the specific information to be released may include, but not limited to: history, diagnoses, immunization record, and/or treatment of drug or alcohol abuse, mental illness or communicable diseases including HIV/AIDS. I authorize this specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that the disclosure of information has been made prior to the receipt of the revocation.

This authorization expires in 90 days from the date of signature, unless I specify otherwise or revoke my authorization. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign and date this form.
I HAVE READ AND UNDERSTAND THIS CONSENT.

_____ _____

Signature of the patient/Executor/Legal Representative Date

Please fax the signed, dated, and completed form to 725-226-1003
Fax services are available at OfficeDepot, UPS, FedEx, and Staples stores. Secured efaxes can be Sent through eFax or iFax efax service.

Note: If you are not the intended receiver of the fax please destroy the faxed information.