

Sanjeev Kohli M.D., PC

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Authorization for Release of Medical Information

www.dr-sanjeev-kohli.com

Personal Information

Social Security #: _____ Date of Birth: ___/___/___ Age: _____ Sex: M F
Patient's Name: Last _____ First _____ Mi _____
Patient's Address: _____ Apt#: _____
City: _____ State: _____ ZIP: _____
Home Telephone: _____ Work Telephone: _____ Ext _____ Cell: _____

(Please check the information you are requesting)

Office Visit Notes Laboratory Reports EKG/Stress/Echo/Holder
 X-Rays Reports Allergy Records Immunizations
 All Records Outside Reports

I _____, do hereby authorize Sanjeev Kohli M.D. PC to release or get
(Patient's Name)

Please Circle on Opinion:

Release or Get Records From

Name of Company/Agency/Facility/Person

Street Address

City, State, Zip Code

Phone Number Fax Number

Purpose of Disclosure:

_____ I do, _____ NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessments and treatment for alcohol and / or drug abuse.

I hereby authorize disclosure of the health information above. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation, I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal regulations.

Signature of Patient/Guardian/Legal Representative

Today Date

***** Note: There will be a charge for personal copy and permanent transfer of your records *****