Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____

Phone Number: _____

I request and authorize: _____

Address: _____

Telephone #: _____ Fax #: _____

to release medical information and records concerning my history, treatment, examinations and/or hospitalizations from _____ through _____ to:

Abhay S. Parikh, M.D.
520 Superior Ave, Suite 320
Newport Beach, CA 92663
Ph: (949) 548-6652
Fax: (949) 548-1435

I understand that this form does NOT authorize the release of any medical information concerning HIV test results and/or treatments, sexually transmitted diseases, psychiatric care, psychological assessment and/or treatment, drug or alcohol abuse treatment or pregnancy termination.

I understand that the release or transfer of the information specified above to any person or entity not specified is prohibited.

_____ _____

Signature of Patient Date

_____

Signature of patient's Legal Representative (if applicable)

_____

Legal Representative's relationship to patient