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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize the use and disclosure of my protected health information about me as described below:

PATIENT NAME _____ DOB _____ Last 4 digits SS# _____

I understand that the information used or disclosed may be subject to redisclosure by the person or class of person or facility receiving it and would then no longer be protected by federal regulations.

REQUESTING RECORDS FROM:	SEND RECORDS TO:
NAME OF PHYSICIAN OR FACILITY	NAME OF PHYSICIAN OR FACILITY
ADDRESS, CITY AND ZIP	ADDRESS, CITY AND ZIP
PHONE AND FAX NUMBER	PHONE AND FAX NUMBER

LAB __
X-RAYS __
MRI/CATSCAN __
PHYSICIANS NOTES __
OPERATIVE REPORT __
DISCHARGE SUMMARY __
ALL MEDICAL RECORDS __
ALL CARDIAC TESTING __

I understand this may include information relating to lab tests of HIV infection or AIDS related conditions, treatment of drug or alcohol abuse, mental behavior health or psychiatric care (excluding psychotherapy notes). I may revoke or withdraw this authorization by notifying the office of Shashi S Bellur MD in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed and my revocation will not affect those actions, I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me whether or not I sign this authorization. This authorization will expire 365 days from the date signed unless otherwise specified.

Signature of Patient	Signature of Patient's Representative
PATIENT'S PRINTED NAME	REPRESENTATIVE'S PRINTED NAME
DATE	DATE