AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

The Undersigned hereby authorizes and requests the release of information contained in the medical records of:

Full Name of Patient: ______________________________

Patient's Address: ______________________________

Date of Birth ______________________ SSN: ______________________

From Dr: ______________________________

Address: ______________________________

____

Release Information to:

- ☐ Shashank Kashyap, M.D.
- ☐ Vijay Kamineni, M.D.
- ☐ Abdali Jan, M.D.
- ☐ Jayanth Gutta, M.D.
- ☐ Stefanie Shire, F.N.P.
- ☐ Lauren Fiandt, AGNP-BC
- ☐ Amber Handshoe, FNP-C

Northeast Internal Medicine
P.O. Box 236
LaGrange, IN 46761

The medical records are needed for the following purpose:

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Information to be released:

_____ Entire medical records for the period of______________________ to ______________________

_____ The following specific portions of the medical records:

___ Discharge Summary
___ History & Physical
___ Consultation Reports
___ Surgery and Path Reports

___ Laboratory Reports
___ X-Ray Reports
___ Progress Notes
___ Other Specific Information
____

I, the undersigned, understand that I may REVOKE this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of (60) sixty days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS related information.

______________________________ ______________________
(Signature of Patient) (Date)

______________________________ ______________________
(Signature of patient or legal representative) (Witness)

Released By: ______________________________ Date: ______________________