FamilyMedicalDoctors
Bharat Desai M.D. - Nilesh Desai M.D.

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RELEASE OF MEDICAL RECORDS

Patient Name _____ DOB _____
(please print)

SS# _____- ____- _____

I hereby authorize the following: _____

to release my medical information to (address listed above) :
Family Medical Doctors, LLC.
Bharat Desai, M.D. & Nilesh Desai, M.D.

These records are to be used for continuing care of the patient above.

Acknowledgement of understanding

* I understand the expiration date of this authorization is one year from date of signature.
* I understand that I may revoke this authorization at any time, by notifying us in writing.
* I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
* I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
* I understand that Family Medical Doctors may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
* I understand a photocopy or fax of this form is the same as the original.

_____ Date _____
Signature of patient, or guardian/representative

_____
Relationship to patient