TAMPA BAY RENAL
Excellence in Kidney Care and Hypertension
Chhavi Gupta, MD

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____

City:_____State: _____ Zip: _____

I authorize the release of the following protected health information:

□ Office Notes /Name of Physician _____
□ Pathology Reports □ Radiology Reports □ Laboratory Reports Date(s): _____
□ Other:_____ □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Insurance □ Other (specify)_____

Send my medical information to: Name: _____
Address: _____

City, State, Zip: _____

I understand that:

By signing this form, I am authorizing the use or disclosure of protected health information as indicated above. I may refuse to sign this authorization, which will not affect my treatment or payment for health care. I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices. If the receiving party is not subject to medical records privacy laws, the information may be redisclosed by the recipient and may no longer be protected by federal or state law. Tampa Bay Renal, LLC or Dr. Chhavi Gupta, shall not be held liable for any consequences resulting from re-disclosure. If the information to be released contains any information about HIV/AIDS this form will provide authorization for the release of such medical information as stated above. This Authorization expires one year after the date signed.

_____ _____
Patient / Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print Name Relationship to patient