ALOK KUMAR, M.D., F.C.C.P.

PULMONARY DISEASES
SLEEP DISORDERS
CRITICAL CARE

Diplomate American Board of Internal Medicine and Pulmonary Disease
Diplomate American Board of

MEDICAL RECORD RELEASE

Authorization for Release of Medical Records.

I, _____ do hereby consent to the disclosure and release by:

_____

_____

_____

of my medical record for continuity of care

To: _____

_____

_____

I acknowledge that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS. I understand that I may refuse to sign this authorization and that it is strictly voluntary. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requestor of receiver is NOT a health care provider, the released information may no longer be protected by federal privacy regulations and may re re-disclosed. I understand that I may see and obtain a copy of the information released pursuant to this authorization, for a reasonable copy fee, if I ask for it. I can get a copy of this form after I sign it.

This authorization is valid for six months from the date signed.

_____ Patient/Legal guardian/Representative
Signature (please circle one)

_____ _____ _____
Social Security Number Date of Birth Date

_____
Witness

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