KALYANI EYE CARE

Sachin D. Kalyani, M.D.

Authorization to Release Medical Records

Our practice will not release your health information without your permission, except as provided in our Notice of Privacy Practices. This form means you are giving permission for us to obtain, release, or disclose your information as described below:

Patient Name: _____ **Date of Birth:** _____

I hereby authorize and request the release of my health information from:

_____

_____

_____

_____

Please send the following information:

_____ All Medical Records

_____ Medical record information for the visit date(s) of _____ to _____

_____ Lab reports

_____ Other: _____

Please release and send my health information to:

Kalyani Eye Care
7556 Teague Road, Suite 410
Hanover, MD 21076

P: (410) 782-3233

F: (410) 799-8585

This information will be released for the following purposes:

Request by Patient Treatment Insurance Other

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION.

Signature: _____ Date: _____