

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Provider:

Jasmine Atwal, MD

Email: info@dratwal.com

1. Patient Information

Patient Name: _____

Date of Birth: ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

2. Person/Organization Authorized to Release Information

I authorize the following provider or facility to release my medical information:

Provider/Facility Name: Jasmine Atwal, MD

3. Person/Organization Authorized to Receive Information

I authorize my medical information to be released to:

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email (if applicable): _____

4. Information to Be Released

Please check all that apply:

☐ Complete medical record

☐ Office visit notes

☐ Laboratory results

☐ Billing records

☐ Medication history

☐ Other (please specify): _____

Date(s) of service to be released:

From: ____ / ____ / ____ To: ____ / ____ / ____

5. Special Authorization (Initial if applicable)

I understand that the following information requires specific authorization under California law:

Initials: _____ Mental health treatment information

Initials: _____ Alcohol or drug treatment information

6. Purpose of Disclosure

☐ Continuity of care

☐ Personal use

☐ Insurance

☐ Legal

☐ Other: _____

7. Expiration of Authorization

This authorization will expire on: One year from the date of signature

8. Patient Rights

- I understand that I may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken in reliance on it.
- I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
- I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
- I understand that I am entitled to receive a copy of this authorization.

9. Signature

Signature of Patient or Legal Representative: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: ____ / ____ / ____
