

Aegis Medical Center, MD, PA Internal Medicine

Authorization for Release of Medical Records

(Print Patient's Full Name)	Birth Date (Month/Day/Year)
,	to release; me of Facility) ax Number ()
All Records OR Dates of Services:	
Discharge Summary Pathology Reports All Records	Emergency Reports History and Physical
Laboratory Reports Progress Notes All Records	Radiology Reports Operative Reports
ECG/EEG/ Cardiac Cath	Other:
I do NOT All Records	
Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.	
RELEASE INFORMATION TO: (Name of Company/Agency/Facility/Person) (Street Address)	Jaya Rao MD Matthew Ward PA-C Dawn Evancho PA-C
(City, State, Zip) PURPOSE OF DISCLOSURE: Referral to Insurance Workers Continuing Investigation	
I hereby authorize disclosure of health information for the above name patient. This Authorization is valid for 12 month from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. ****** Copying of medical record and releasing them to your new MD if free of charge ***** ***** Medical records requested/released to the patient requires a \$35 prepayment ******	
Signature of Individual or Guardian	Month / Day / Year