AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To Abundant Health Holistic Center 352 483-9355 call 1st to fax

I, _____ D.O.B. _____ LAST FOUR OF SS#____
(Patient's name)

GIVE: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY MEDICAL STATUS:

These records may be released directly to the above named patient or mailed to:

□ Solara Attatharya, DOM, AP, DNBHE
2200 South Bay St. Suite. B., Eustis, Fl 32726 352 483-9355 _____

□Or I give Solara Attatharya, DOM, AP, DNBHE
2200 South Bay St. Suite. B., Eustis, Fl 32726 352 483-9355 _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY MEDICAL STATUS TO:

_____

_____

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED FOR RELEASE: □ **All available: □ Medical records, □ Lab reports □X-Rays □+Ct Scans, etc**
In addition, if there are any comments, opinions or information your office can provide relative to the aforenamed that might be helpful in providing him/her with health care they would be most appreciated. If there is a specific date by which you need the materials back, please include a note so informing me. This note when delivered by the aforenamed authorizes him/her to carry out the records/radiographs to be promptly delivered to my office. Thank you for your time and assistance. If you have any questions please don't hesitate to call me.

_____

Patient Signature: _____ Date _____

Doctor Signature: _____ Date _____

Please note: Florida Statute 456.057 (6) states: Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any person shall, upon request of such person or the person's legal representative furnish in a timely manner, without delays for legal review, copies of all reports and records relating to such examination or treatment, including X-rays, and insurance information. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered.

EXPIRATION DATE OF THIS AUTHORIZATION: _____/_____/_____

Our Notice of Privacy Practices provides information about our use of a patient's protected health information (PHI). The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.