AUTHORIZATION FOR RELEASE MEDICAL RECORDS

Patient Name/DOB: ____

I hereby authorize: ____
(Name and address of person/facility to release records)

I authorize the release of my medical records to Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE and also authorize Dr.Rangi to release my medical records by Capitol Endocrinology Inc. / Jaiwant Rangi, MD, FACE to other physicians / Institutions for continued medical treatment and help manage my medical condition.

Jaiwant Rangi, MD, F.A.C.E.
Capitol Endocrinology, Inc.
3106 Ponte Morino Dr
Cameron Park CA 95682

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _________________________

This authorization is subject to written and signed revocation by the member/patient at any time. The written revocation will be effective upon receipt.

The recipient of these records may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Type of records to be disclosed: (check all that apply)

_____ Medical Information (progress notes, lab and diagnostic imaging results)

_____ Billing Records

_____ Mental Health Records

The recipient may use the health information authorized on this form for the following purposes:

____

A copy of this authorization is just as valid as the original.

Patient Signature: _______________________________ Date Signed: ______________

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