AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____

(PRINT Patient's Full Name) Birth Date (Mo/Day/Yr)

_____ _____

(Street Address) Social Security Number

_____ _____

(City, State, Zip Code) Home Phone

(PARENT OR GUARDIAN) _____

At the request of the individual, I _____ , do hereby authorize_____ to release:

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	_____ ENTIRE CHART
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	_____ OTHER_____
_____ OPERATIVE NOTES		

____ I do ___ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) of HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO: **Dr. Naga Chigurupati**
2207 Executive Drive, Suite B
Hampton, VA 23666
Phone: (757) 224-8919
Fax: (757) 663-5682

PURPOSE OF DISCLOSURE:

__X__ REFERRAL TO SPECIALISTS

OTHER (SPECIFY): _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect 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 person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

SIGNATURE OF INDIVIDUAL OR GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE DATE

PLEASE PROVIDE CURRENT TELEPHONE NUMBER IN THE EVENT WE NEED TO CONTACT YOU: _____