SLEEP & LUNGS
Naga Chigurupati, MD

2207 Executive Drive, Suite B, Hampton, Va 23666 • Phone 757-224-8919• Fax 757-663-5682

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
☐ HISTORY & PHYSICAL
☐ PROGRESS NOTES
☐ OPERATIVE NOTES
☐ PATHOLOGY REPORTS
☐ LABORATORY REPORTS
☐ RADIOLOGY REPORTS
OTHER _____
☐ EMERGENCY REPORTS
☐ ENTIRE CHART

☐ 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) 224-5682
Fax: (757) 663-5682

PURPOSE OF DISCLOSURE:

☒ 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 affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to redisclosure 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: _____