KUNJAN P. THAKOR, M.D., P.A.
Board Certified in Infectious Diseases
5930 W. Parker Rd. ▪ Suite 600 ▪ Plano, TX 75093 ▪ (972) 378-3242 ▪ Fax: (972) 378-3206

AUTHORIZATION FOR RELEASE OF INFORMATION FROM OTHER MEDICAL FACILITIES

PATIENT NAME:	**DATE OF BIRTH:**

This form is a requirement for our office so we are able to receive medical records and any other necessary documents from other medical facilities.

If you DO NOT wish to authorize the office at this time to request and receive your records,
please leave this form blank.

❑ Consultation Reports	❑ List of All Medications	❑ Hepatitis Information	❑ Test Results (Labs, X-Rays, etc)
❑ Discharge Summary	❑ Mental Health/Alcohol and Drug Abuse Treatment	❑ History and Physical Exams	❑ All of the Above
❑ Progress Notes	❑ Statement of Charges and Payment	❑ AIDS or HIV Information	

The purpose of the disclosure:

❑ Request of Individual	❑ Change of Doctor	❑ Legal Investigation
❑ Referral to Specialist	❑ Insurance	❑ Other: (Please Specify)
❑ Continuing Care	❑ Workers Comp	

I understand that my medical information may include sensitive health information. Communicable diseases such as Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), if diagnosed, will be included in my medical records. I further understand that my medical information could indicate that I am undergoing treatment for psychological or psychiatric conditions or substance abuse.

I understand that I may revoke this authorization **in writing at any time**, except to the extent that the office of Kunjan P. Thakor has already relied on this authorization. The written revocation should be addressed to the office of Kunjan P. Thakor. Unless otherwise revoked, I understand that the date or event upon which this authorization *expires* is one year from the date of signature. A copy of this authorization is considered as valid as the original.

I understand that if the recipient authorized to receive the health information is not a covered entity (e.g. insurance company or non-health care provider); the release information may no longer be protected by federal and state privacy regulations.

I understand that Kunjan P. Thakor will not condition treatment, payment, enrollment or eligibility for benefits upon obtaining of this form. I understand I may be charged retrieval/processing fee and for copies of medical records according to Texas Hospital Licensing Law.

_____ _____
PATIENT SIGNATURE ***DATE***

_____ _____ _____ _____
PRINT LEGAL REPRESENTATIVE NAME ***LEGAL REPRESENTATIVE SIGNATURE*** ***DATE*** ***RELATIONSHIP TO PATIENT***