Sant P. Chawla M.D.

DIPLOMATE OF AMERICAN BOARD OF MEDICAL ONCOLOGY
2811 Wilshire Blvd * Suite 414 * Santa Monica, CA 90403
TEL. (310) 552-9999 * FAX (310) 201-6685

REQUEST FOR RELEASE OF MEDICAL RECORD INFORMATON

I REQUEST AND AUTHORIZE THE FOLLOWING PHYSICIAN(S)/ FACILITIES TO RELEASE INFORMATION FROM MY MEDICAL RECORD.

1. _____
Physician/ Facility **Phone:** **Fax:**

2. _____
Physician/ Facility **Phone:** **Fax:**

3. _____
Physician/Facility **Phone:** **Fax:**

4. _____
Physician/Facility **Phone:** **Fax:**

5. _____
Physician/Facility **Phone:** **Fax:**

Patient Information:

Printed Name: _____ **Date of Birth:** _____ **S. S. #** _____

Address: _____

Telephone: _____ **Alternate Phone:** _____ **Pt. Id #:** _____

Information to be released:

◊ Discharge Summary	◊ Consultation reports	◊ X-Ray Films / Images
◊ History & Physical	◊ X-Ray reports	◊ Other:
◊ Laboratory test results	◊ Emergency Room Records	◊ Other:
◊ Complete Health Records	◊ Progress Notes	◊ Other:

Purpose of Request:

◊ Treatment or Consultation	◊ At request of Patient	◊ Other:

Who and Where to Send/ Release Information:

Sant P. Chawla M.D.
2811 Wilshire Blvd # 414 Santa Monica, CA 90403
T: (310) 552-9999 F: (310) 201-6685

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Dr. Sant P. Chawla at 2811 Wilshire Blvd Suite 414 Santa Monica, CA 90403. Unless revoked, this authorization will expire on the following date or event,_____ or two years from the date of signature, unless otherwise specified.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

* I understand if my medical records contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C, and/or other sensitive information I agree to its release:

Initial One: ____Yes ____No

- I understand if my medical records contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release:
- **Initial One:** ____Yes ____No

Signature of Patient or Personal Representative Who May request Disclosure

I can inspect or copy the protected health information to be used or disclosed. I authorize the above listed facilities/physician(s) to disclose the protected health information specified above.

Signature: _____ Date: _____
Authority to Sign if not patient: _____ Relationship: _____