

MANI K MD PA

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Authorization to Release Medical Records

Complete and sign. Records are released only with a valid authorization or as required by law.

1. Patient

Patient name _____ Date of birth _____

Phone _____ Address, city, state, ZIP _____

2. Send the records to

I authorize MANI K MD PA to release the records below to:

☐ Me, the patient ☐ Another physician or clinic ☐ Insurance ☐ Other

Name _____ Phone / fax _____

Address, city, state, ZIP _____

Send by: ☐ Pickup ☐ Mail ☐ Fax ☐ Patient portal Fax number _____

3. Records to release

Dates of service: _____ through _____ ☐ All dates on file

☐ Office visit notes ☐ Lab results ☐ Imaging reports ☐ Immunizations

☐ Medication list ☐ Billing records ☐ Complete chart for the dates above

Other (describe) _____

Sensitive information — release only if checked and initialed:

☐ Mental / behavioral health Initials _____ ☐ Substance use disorder Initials _____

☐ HIV / AIDS or STD Initials _____ ☐ Genetic information Initials _____

4. Purpose and expiration

☐ My own records ☐ Continuing care ☐ Insurance ☐ Personal ☐ Other: _____

This authorization expires on _____ If blank, it expires one year from the date signed.

5. Your rights

I may revoke this authorization in writing at any time, except for records already released. Treatment, payment, and eligibility for benefits will not be conditioned on my signing. Once released, the recipient may redisclose the information, and federal privacy law may no longer protect it. I may refuse to sign, and refusal will not affect my care. I may have a copy of this form. Copies, or a summary or narrative, will be provided within 15 business days after this form and any fee are received. A fee may be due before non-urgent records are released: paper, up to \$25 for the first 20 pages and \$0.50 per page after that; electronic, up to \$25 for 500 pages or fewer and \$50 for more than 500 pages; an affidavit, if requested, up to \$15. No fee is charged for a disability-benefits request.

6. Signature

I have read this authorization, or it has been read to me, and I understand it. I authorize the release described above. If I am signing for the patient, I have legal authority to do so.

Signature of patient _____ Date _____

Printed name _____ Phone _____

Representative signature, if not the patient _____ Relationship _____ Date _____

7. Office use only

Received _____ By _____ ID verified ☐ Fee \$ _____ Sent _____

Notes _____