AUTHORIZATION TO DISCLOSE MEDICAL RECORDS TO A SQUARED PRIMARY CARE, PLLC

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Address:_____

_____

Patient's Telephone Number: _____

I authorize _____ to release a copy of my medical record to:

Anjula Agrawal, M.D., F.A.C.P.
A Squared Primary Care, PLLC.
4125 Albemarle Road, NW, Suite 200
Washington, D.C. 20016

The purpose of this request for medical records is: ❑ Treatment ❑ Attorney ❑ Insurance ❑ Disability
❑ Workers Compensation ❑ Self ❑ Other: _____

Dates of service: ❑ All **or**: _____

Records to be released: ❑ Entire Record **or:**

❑ Physical Exam	❑ Nursing Notes	❑ Laboratory Data	❑ Social Services
❑ Discharge Summary	❑ Imaging Reports	❑ Rehab (PT/OT/ST)	❑ Other Diagnostic Reports
❑ Consultations	❑ Immunization Record	❑ Pharmacy	❑ Dietary
❑ Operative Notes/Procedures	❑ Mental Health Assessments		❑ Respiratory Report
❑ Summary of Record Set	❑ Other: _____		

I understand that I may revoke my authorization to use/disclose my protected health information by completing a revocation of authorization. This does not affect disclosure of information already made. I understand that my provider may not condition treatment on the completion of this authorization. This authorization will expire one year from the date signed or earlier if otherwise stated: _____.

I understand that the above indicated health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where applicable. It may also include information about behavior or mental health services, and treatment for drug and alcohol abuse in accordance with 42 CFR Part 2; which prohibits redisclosure, unless such further disclosure is expressly permitted by my written consent. This authorization does not apply to any mental health information obtained after the signature date below. The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure may be made pursuant to a valid authorization by the patient or as provided in Title III or IV of that Act. The Act provides for civil damages and criminal penalties for violation.

Signed: _____ Date :_____

(Signature of Patient or Personal Representative)

_____

Relationship to Patient/authority to act on behalf of the Patient.