DR. MANOHAR G REDDY, MD PA
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Melbourne, FL 32935
(321) 752-5544 • Fax (321) 752-5957

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Dr. Manohar G Reddy, MD PA to transfer, release, or obtain information on:

Patient Name:_____ **DOB:**_____ **SS#** _____

***** This Authorization will remain in effect until revoked in writing by the undersigned*****

Date (s) of Treatment: ❑ All dates **Or** Specific Dates: _____ thru _____

Please Check Specific Information Requested

❑ All Medical Records
❑ The most recent 2 years or pertinent information (Chart notes, labs, x rays, and special tests)
❑ Specific information (please specify): _____

❑ OBTAIN FROM	❑ SEND OR FAX TO:
Physician/Institute _____ Phone: _____ Fax: _____ Address _____ City, State, Zip _____	Physician/Institute _____ Phone: _____ Fax: _____ Address _____ City, State, Zip _____

Purpose for which the disclosure is being made: (check one)

❑ Attorney ❑ Insurance ❑ Doctor ❑ Personal

*I understand that there may be a fee of $1.00 per page for the first 25 pages and then $0.25 a page there after plus applicable postage and handling when necessary for these records to be sent out.
*I understand that I may refuse to sign this Authorization, and that the institutions or individual's names above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
*I understand that I have the right to revoke this authorization at any time. 1 understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Manohar G Reddy, MD PA where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
*1 understand that the information in my record may include sensitive information about behavioral or mental health services, treatment for alcohol and/or druse abuse. It may also contain information related to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
*I hereby release the originating office or facility and its employees from any and all liability that may arise from the release of this information as **I** have directed.

_____
Patient Name or Authorized Signer

Relationship to patient: (check one)
❑ Self ❑ Legal Guardian ❑ Power of Attorney

_____ _____
Signature Date

If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records