OFFICE OF DR. MANOHAR REDDY

2551 W EAU GALLIE BLVD, MELBOURNE, FL 32935

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Patient Name: _____DOB: ___/____/___

Social Security #: _____-_____-_____ Phone: ( ) _____

Purpose of Release: _____

I hereby authorize Dr. Manohar Reddy to: ❑ release to ❑ obtain from

Name: _____

Address: _____

City, State, Zip: _____

Any information, including diagnosis and medical records of any treatment or examination rendered to me during the following period:

❑ the past twelve (12) months, or
❑ from the time period from _____ to _____

and to include any Federal and State protected information under Florida Statute 394.459(9) Psychiatric information, Florida Statute 397.501 and 397.112 Drug and/or Alcohol Abuse information, and Florida Statute 381.004 and FAC 10d-93.064 Human Immunodeficiency virus test results (HIV testing, AIDS and related conditions).

- I understand and direct that this authorization remain in effect until I revoke the authorization in writing to the Privacy Officer at the address above.
- I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I hereby release Dr. Manohar Reddy and his employees from any and all liability that may arise from the release of this information as I have directed.

Signature: _____ Date: _____
(Patient, parent if minor, or legal guardian)

Relationship to Patient if signed by personal representative: _____

Witness: _____ Date: _____

❑ Please check here if records will be picked up. Someone will call you when records are ready.
❑ Please check here if records are to be mailed.