Aruna S Nathan
MD PA

10605 Concord Street, Suite 302
Kensington, MD 20895
Phone: (301) 949-1010
Fax: (301) 933-3077

Authorization to Disclose Protected Health or Billing Information

Patient Information: I give permission to release the health information of: (One patient per form)

Patient Name: _____ Date of birth: _____

Street Address: _____

City, State, Zip: _____ Telephone: _____

Email address: _____

Release Information From:	Release Information To:
(list applicable Facility(s) and/or Practice(s))	(Name of facility, person, company) (Relationship)
	(Street address or PO Box, City, State, Zip code)
	(Phone number)

Purpose of Release (check reason): ☐ Request of individual / personal ☐ Insurance ☐ Disability ☐ Workers Compensation
☐ Legal purpose including discussions & proceedings ☐ Other: _____

Must fill in dates of treatment for records to be released: Treatment dates FROM: _____ TO: _____

Hospital (check all that may apply):

☐ Hospital Abstract

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Diagnostic Test Results
- ☐ Medications
- ☐ Allergies
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Emergency Record
- ☐ Cardiac Reports/EKG
- ☐ Laboratory Reports
- ☐ Radiology/X-Ray Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Other: _____

☐ Entire Record (not including psychotherapy notes)

Office/Clinic (check all that may apply):

☐ Office / Clinic Abstract

- ☐ Office Visits
- ☐ Physical Exam
- ☐ Consultation Reports
- ☐ Diagnostic Test Results

☐ Laboratory Reports
☐ Radiology Reports
☐ Medications
☐ Billing Information
☐ Other: _____

☐ Entire Record (not including psychotherapy notes)

Format (only select one):
☐ Paper copy (charges may apply) ☐ Electronic copy
☐ Other: _____

Delivery Method:
☐ Reg. US Mail ☐ Pick-up
☐ Other: _____

I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or pr actice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in complian ce with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may n o longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless another date or event is written here: _____

Signature: _____ Print name: _____ Date/Time: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signa ture is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Parent ☐ Next of Kin
☐ Other: _____

Signature of minor: _____ Print name: _____ Date/Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

For office use only

Date of release: _____ via ☐ mail ☐ fax ☐ other _____ ☐ ID verified ☐ DL/Other ID _____

Employee Name & Title: _____ Employee User ID: _____ Date/Time: _____

Patient Name: _____

DOB: _____