AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Aman Mongia, MD
Anu Mongia, MD

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Cartersville, GA 30121
Phone: 678- 721-6971
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Patient:_________________________________SS#:__________________________________

Date Of Birth:_______/_______/_______ Telephone #:_____________________________

Address:____
City: ________________ State:_________ Zip:_______________

I hereby authorize **Center For Infectious Disease /Allergy, Asthma &Sinus** to release/receive the health information indicated below that is contained in my patient records to the Recipient/Sender's named below. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and HIV/AIDS test results or diagnoses and Psychotherapy notes.**

Recipient/Sender:____
Telephone#:_______________________________ Fax#:__________________________________
Address:____
City:_____________________________ State:_______________ Zip#:________________

Reason For Disclosure:____________________________________

	All Records		History & Physical		Laboratory Reports		Radiology Reports
	Nurse Notes		Medication List		Demographics		Operative Reports
	Special Test/ Therapy		Rehabilitation Services		Other:		Other:

This Consent is subject to revocation at any time except to the action had been taken thereon. **This Authorization and consent will expire in six (6) months from the date of authorization written below.** I understand that the recipient of my health information may be charged for the service of releasing medical Information. Your health care (or payment of care) will not be affected by whether or not you sign this Authorization. Once your health care information is released, redisclosure of your health care information by the recipient my no longer be protected by law.

____ / _____________________ ______/_______/_______
Signature of Patient/ Guardian *Print name* *Date signed*

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Relationship if not Patient