Lakshmi Sathya MD

1299 Water Lily Way Unit #90
San Jose CA 95129
Tel: 650-666-0033
Fax: 650-300-4647
www.LakshmiObGyn.com

Authorization to Release Medical Records/Information to Patient or Another Provider

Patient Name: _____ DOB: _____ Phone #: _____

I, _____, do hereby authorize the release of the below listed medical records from the following office:

Dr. Lakshmi Bangalore Vatsan Sri

1299 Water Lily Way Unit #90, San Jose, CA 95129

Phone #: (650) 666-0033 Fax #: (650) 300-4647

- ❑ Entire Medical Record (includes all Patient Information listed below)
- ❑ Mental Health
- ❑ Radiology
- ❑ HIV/AIDS/STD Screenings
- ❑ Communicable Diseases
- ❑ Only the following: _____

Please release this information in a timely manner to the following office:

Name of Provider: _____

Address: _____

Phone#: _____ Fax#: _____

For the purpose of: _____

_____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying and shipping fees and any applicable sales tax that may be charged.

Patient/Spouse/Guardian Name: _____ Relationship to Patient: _____

Patient/Spouse/Guardian Signature: _____ Date: _____