RECORDS REQUEST

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:**«FirstName» «LastName»**

Patient's Date of Birth:**«DOB»** Patient's SSN:**«SSN»**

A. Person(s) or Organization(s) authorized to provide the information:(records are coming from)

B. Person(s) or Organization(s) authorized to receive the information: **Sanjeev Khurana, M.D.**
604 W Warner Road, Suite D4
Chandler, AZ 85225

C. Specific description of the information that may be used or disclosed (including date(s)): **All Notes, Labs and Consult Reports**

D. Specific description of how the information will be used: **Continued Medical Treatment**

1) I understand that this authorization will **expire** on / / .
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in **A** (above) in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable.
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would **no longer be protected** by these regulations.

____ Thursday, March 01, 2007
Patient's Signature or Patient's Representative Date

____ «RelToPatient»
Printed Name of Patient's Representative Relationship to Patient

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

You have the right to alter this request. We have preprinted options for your convenience. You may alter these items if needed.

You have the right to receive a copy of this form