Rakesh Shah, MD ● BT Turakhia, MD ● Jinesh Shah, MD ▪ Francis Uricchio, MD
Salik Nazir, MD ● Andrew Badalamenti, MD

AUTHORIZATION FOR REQUEST OF MEDICAL RECORD INFORMATION

Patient Name: _____

Social Security: _____

Date of Birth: _____

PLEASE NOTE: IF THERE ARE OVER 20 PAGES PLEASE MAIL RECORDS

The patient listed above authorizes the following healthcare Provider/Facility to disclosure:

Facility Name: _____

Facility Address: _____

Phone: _____ Fax: _____

Dates and Type of information to disclose:

□ Complete Records	□ **Lab Reports**	□ Diagnostic Images
□ All Office Notes	□ most recent full report	□ Drug/Alcohol Notes
□ All Hospital/Surgical Records	□ all reports	□ Psychotherapy Notes
□ All records from to		□ Other:

The purpose of the disclosure: ☐ Continuation of Care ☐ Referral ☐ Patients Request

Please send requested records to:

Bay Area Heart P.L.L.C

Rakesh Shah, MD ● BT Turakhia, MD ● Jinesh Shah, MD ▪ Francis Uricchio, MD
Salik Nazir, MD ● Andrew Badalamenti, MD

450 Blossom St. Ste. D, Webster, Texas 77598

Phone: 832-905-5940 ● Fax: 832-905-5941

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Bay Area Heart PLLC. Unless revoked earlier this authorization will expire 180 days from the date of signing (6 months) or on the following date or event: _____

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no-longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under applicable state of federal laws and regulations. I further understand that the person(s) I an authorizing to use or disclose my information may receive compensation for doing so.

_____ _____

Signature of Patient/Legal Representative **Date**

_____ _____

Printed name of Patient/Legal Representative **Relationship to patient**