Medical Records Release

Eric S. Hollabaugh, M.D., P.A.
Edward L. Parry, M.D., P.A.
Gunjan M. Modi, M.D., P.A.
Michael J. Wells, M.D., P.A.

(Authorization for Disclosure of Confidential Information)

Patients Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

I, _____, hereby give permission to release any pertinent medical information, pathology results, and treatment performed by Eric S. Hollabaugh, M.D., Edward L. Parry, M.D., Gunjan M. Modi, M.D., and Michael J. Wells, M.D. to the following:

Dr. or Name: _____

Address: _____

City: _____

Phone Number: _____ Fax Number: _____

The Authorization is given freely with the understanding that:

Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

A photocopy or fax of this authorization is as valid as this original.

I may revoke this authorization at any time, except where information has already been released. This authorization is valid for sixty (60) days from the date it is signed, or sooner is noted below.

Eric S. Hollabaugh, M.D., Edward L. Parry, M.D., Gunjan M. Modi, M.D., and Michael J. Wells, M.D., as well as, their employees, officers, and physicians, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patients Name (Printed) Date

_____ _____

Patients Signature or Guardian Revocation Date if Different from Above