Sharad R Vyas, MD
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Palm Bay, FL 32905
321- 725-8111 phone (321) 984-0552 fax

Authorization for Release of Protected Health Information

Please allow 2-3 weeks for medical records requests

Please Print Clearly

Patient's Full Name: _____ Date of Birth_____

Address: _____

City, State, and Zip: _____

Phone #:_____Work #_____

I, the undersigned authorize Dr Sharad Vyas to release to: _____obtain from: _____

Previous Healthcare Provider: _____

Address: _____

City, State and Zip: _____

Please release the information from medical records, for the care and treatment that the above patient received for the dates of service listed: _____to_____

The Protected Health Information may be used for continuing healthcare, insurance, legal or personal purposes.
Medical records are to include any and all federal and state protected information without
Limitations to include diagnosis, treatment and examinations related to mental health, drug and alcohol abuse, HIV/AIDS testing and sexually transmitted diseases.
By signing this release, I understand that the authorization will remain in effect ct until revoked in writing. Dr Vyas is authorized to use outside vendors for the purpose of copying and providing the information requested.
I understand that the State Law prohibits the re-disclosure of the information disclosed to the persons/entities listed without my further authorization, but Dr Vyas cannot guarantee that the recipient of the information will not re-disclose the information contrary to such prohibition.
I understand I have the right to inspect and obtain a copy of any information disclosed.
I hereby release Dr Vyas and his employees from any and all liability that may rise from the release of information as I have directed.
I understand that if I have requested records for personal reasons, I may be charged $1.00 per page for every page copied. This fee may be waived for copies provided to healthcare providers, insurance companies or other organizations for treatment, billing or operation purposes.

Signature: _____ Date_____

Relationship to patient_____

Witness: _____ Date_____