

# New Patient Information Release Authorization Form

**Patients Name:**

**Birth Date:**

**Social Security Number:**

**Previous Name:**

I request and authorize the following entity to release health information of the patient named above:

**Physician's Name:**

**Address:**

**City, State:**

**Zip Code:**

**Phone Number:**

**Fax Number:**

**TO: Yatish Goyal, M.D. 970 E. Washington Street, Suite 4D, Medina, Ohio 44256**

**Priyanka Sahni, M.D. 970 E. Washington Street, Suite 4D, Medina, Ohio 44256**

**Mazen Jarach , M.D. 970 E. Washington Street, Suite 4D, Medina, Ohio 44256**

**FAX: (330) 723-1254 PHONE: (330) 725-7277**

**This request and authorization applies to:**

**Only health care information relating to the following treatment, condition, or date of treatments:**

**All health information**

**Other:**

**This information will be disclosed for the following purposes:**

**At the patient's request:**

**This authorization expires on:**

**(cannot exceed six months)**

**I understand that I may revoke this authorization in writing at any time except to the extent that the above entity has already released information after I gave this authorization. I may revoke this authorization by writing a letter to the above entity giving the name or other specific identification of the person(s) that I no longer want to receive information.**

**Once the above entity gives out the information that I want released, I know that they have no control over the information. That individual or organization that I authorize to receive the information might re-disclose it. Federal or State privacy laws may no longer protect the information.**

**SIGNATURE OF PATIENT'S AUTHORIZED REPRESENTATIVE**

**DATE SIGNED**

**RELATIONSHIP IF SIGNED BY ANYONE THAN THE PATIENT**