Meena Medical Group, Inc.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name (please print) _____ Today's Date _____

Patient SSN _____ Patient Date of Birth _____

Person(s), Class of Persons, or Organization To Release Information to:

Qais M. Wahidi, MD

Name

1600 Creekside Drive, Suite 2300 | Folsom | CA | 95630

Mailing Address | City | State | Zip

916-542-7467 | 916-932-4879

Phone Number | Fax Number

Information to be Released (What do you want sent or released, check the appropriate Box)

- ☐ Entire Medical Records
- ☐ Dates:_____ to _____ .
- ☐ Copies of Films/Images.
- ☐ Clinic (office visit, lab, radiology, medicines, immunizations)
- ☐ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)

Previous PCP:_____ Phone:_____ Fax:_____

Address: _____

Description and Purpose of Information to be Released:_____

_____

Expiration Date or Related Event That Will Cause Authorization to Expire: _____

(If no expiration date is specified, this authorization will expire one (1) year from the date it was signed).

By signing this form, I authorize the release protected health information about me (or another person for whom I have authority to sign) to the Center for Primary Care for the time period, purpose, and extent described above. My signature indicates that I fully understand and acknowledge the following:

- My health record may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, blood alcohol and drug testing, and treatment for alcohol and drug abuse.
- The protected health information to be used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal law.
- I have the right to refuse to sign this authorization. CPC will not condition treatment, payment, enrollment, or benefits eligibility on my signing this authorization.
- I have the right to revoke this authorization in writing at any time to the extent that the use or disclosure has not already been made. I may do so in person at the office where my records are maintained.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Name of Patient or Authorized Representative (please print) | Relationship to Patient (please print)