Neela Parekh, M.D. FAAP
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AUTHORIZATION TO RELEASE
Protected Health Information

PATIENT'S NAME (print): ______________________________ DATE OF BIRTH: ______________________________

I, ______________________________________ Phone: ____________________
(Parent or Legal Guardian)

hereby authorize use or release of the above named patient's health information as described below.

___ Progress Notes ___ Immunization Record
___ Physical Exams ___ Growth Charts
___ Consultations ___ Hospital Records
___ Lab/X-ray/Image reports ___ Other (Specify) _______________

To disclose to Name: _______________________________
Address: ____
____
Phone Number: ____________________________

NOTICE OF RIGHTS AND OTHER INFORMATION:

- I understand that authorizing release of this information is voluntary. If I refuse to sign this authorization, the requested information will not be released.
- This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____________.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me (or legal representative), and delivered to:
  Neela Parekh, M.D.
  15000 Los Gatos Blvd. #3
  Los Gatos, CA 95032
  I understand that the revocation will not apply to information that has already been released based on this authorization.
- Information released based on this authorization could be re-released by the recipient and might no longer be protected by federal law. However, California law prohibits the person receiving health information from further release without authorization unless required or permitted by law.
- I may inspect or obtain a copy of the information for which I am authorizing release.

Name (Please Print):________________________

Signature:__________________________ **Date**:____/____/_____