Patient Medical Record Release Form

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In order to comply with HIPPA regulations, we cannot release your Medical Information to anyone but, you the patient. Consequently, if you would like us to discuss your Lab results, Diagnostics OR other medical findings with a relative or significant other, please list their name(s) in the space below, sign and date.

I _____ authorize, Dr. Nimisha Trivedi, MD to release my medical information to:

_____

_____

_____

Signed: _____

Date: _____