Dr. Bawa & Associates P.A.
Board Certified, Internal Medicine
4476 Legendary Drive Destin FL 32541
Phone: **(850) 586-7890** Fax: **(850) 586-7891**

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____DOB: _____
SSN: _____Phone: _____
Address: _____
_____

I, (Pt.)_____ authorize (Drs.Name)_____
(Address)_____
(Fax#)_____(Telephone#)_____
the release of my medical records to Dr. Nitin Bawa. The records may be faxed or mailed as necessary.

Description of the information to be disclosed: Last two (2) years only

- ❑ Medical Transcripts
- ❑ Lab Reports
- ❑ Pathology Reports
- ❑ Radiology Reports
- ❑ Medication Sheets
- ❑ Other_____

I understand that:

1. The released information may contain alcohol, drug abuse, HIV testing, HIV results, AIDS or any other sexually transmitted disease information.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken PRIOR to receiving this revocation. This written revocation must be received by Dr. Nitin Bawa at Dr. Bawa & Associates P.A. at 45 Sugar Sand Lane, Suite A, Seagrove Beach, FL-32459 before the revocation becomes effective.
3. My protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient, and the privacy of my protected health information may no longer be protected by law.
4. N.B.P.A. and its staff are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this authorization.
5. I may inspect and obtain a copy of the health information described on this form, for a reasonable copy fee, if I ask for it after signing this authorization form.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____