Dolar Koya MD
Komal Koya DO
333 Chestnut St., Suite 205 Hinsdale IL, 60524
Telephone: (630) 654-3376
Fax: (630) 655-3872

Patient Name: _____ Date of Birth:_____

Address: _____

Phone Number: _____

I hereby authorize that the protected health information regarding the above named person be forwarded as follows:

FROM	TO
☐ Dr. Komal Koya ☐ Dr. Dolar Koya 333 Chestnut St, Suite 205 Hinsdale, IL 60521	_____ _____

_____ Entire Medical Record

____ X-ray _____ Ultrasound _____ Mammogram reports (check one requested)

____ Operative reports Specific Procedure:_____

_____ Other:_____

To be <u>included</u>, the following items must be specifically checked:

_____ Mental Health Treatment Records _____ Alcoholism Treatment Records

_____ Drug Abuse Treatment Records _____ HIV/AIDS Records

The above information for the following period of time shall be released from:

_____ to _____

(Date) (Date)

The purpose of the authorization is:

_____ Moving _____ Insurance Conflict _____ 2nd Opinion _____ Transfer of Care _____ Primary Physician

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above information, I understand that it will not be disclosed, except as provided by law.
I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
I understand that I may revoke this authorization at any time be giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release if Confidential Health Information will terminate on _____.

I understand that there will be a fee charged to me to cover the cost of copying and sending my records.

_____ _____

(Signature of Patient) (Date)

If you are not the patient, please specify your relationship to the patient: _____