Office Locations:
15245 Shady Grove Rd # 130
Rockville, MD 20850
(301) 527-1650

Business and mailing address:
P.O. Box 10067
Gaithersburg, MD 20898

Ravi Passi, M.D., FACP, CMD

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME_____ DATE OF REQUEST_____

DATE OF BIRTH _____

1. I authorize the below named Facility/Doctor/ Hospital to disclose the above named individual health information.
   FACILITY/DOCTOR/ HOSPITAL NAME _____

   FULL ADDRESS, PHONE AND FAX NUMBER _____

   _____

   REASON FOR TRANSFER _____
2. Type and amount of information to be disclosed is as follows (indicate dates where appropriate)

____ Entire record	____ Problem list
____ Medication list	____ Immunization record
____ Most recent History & Physical	____ Consultation reports
____ Most recent Office Visit/ Progress Notes	____ Laboratory results
____ X-Ray results	____ Hospital records

3. I understand that information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS). Or human immunodeficiency virus (HIV). It may also include information about behavioral/ mental health services and treatment for drug or alcohol abuse.
4. This information may be disclosed to and used by RAVI PASSI, MD PC 15245 Shady Grove Road Suite 130, Rockville, MD 20850.
   MAIL REQUESTED RECORDS TO: RAVI PASSI, MD PC, 15245 Shady Grove Road # 130 Rockville, Maryland 20850
5. I understand that I have a right to revoke this authorization at any time, in writing by sending written notification to: RAVI PASSI MD, PC/ PRACTICE ADMINISTRATOR, 15245 Shady Grove Rd # 130 Rockville, MD 20850. I understand that revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State law.
6. I understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use of disclosure.

_____ _____
Signature of Patient of Guardian/ POA Date

_____
Relationship to patient

_____ _____
Witness Date