Affiliated Physician
MDVIP

Viraj V. Tirmal, MD
Internal Medicine

Viraj V. Tirmal, MD LLC

REQUEST FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient Name (print) Date of Birth

_____ _____
Daytime Telephone Number Last 4 digits of Social Security #

_____
Address

I authorize Viraj V Tirmal MD LLC to disclose my medical records to the following:

1. ☐ Another Provider

   Name of Provider: _____

   Address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

   E-mail address: _____ Fax: _____

2. ☐ Myself

3. ☐ Another Person

   Name: _____

   Relationship: _____

   Address: _____

   City: _____ State: _____ Zip: _____ Phone: _____

   E-mail address: _____ Fax: _____

Select the information that you are authorizing to be disclosed:

☐ Entire medical record including films/imaging

☐ Other: _____

I understand that the 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 or mental health services, and treatment for alcohol and drug abuse. Furthermore, I understand that this information will be disclosed from records protected by federal law, including 42 C.F.R. Part 2. These records are prohibited from further disclosure without written patient consent unless otherwise mandated by law. Only such records and/or information believed necessary for the purpose expressed above shall be released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this request, I must do so in writing and present my written revocation to Viraj V Tirmal MD LLC at the contact information above. I understand that the revocation will not apply to information that has already been released in response to this request. This authorization will expire in one year unless another date/event is specified herein.

I understand that I may receive a copy of this form after I sign it and inspect and copy information to be used or disclosed. I also understand there may be a charge for this information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure treatment, payment, enrollment, or my eligibility for benefits; however, the identified records will not be disclosed.

_____ _____

Signature of Patient or Patient's Representative Relationship to Patient

_____

Date

Submit