Vipul Dua, MD
2800 Tamarack Ave
Suite 106
South Windsor, CT 06074
ph-860-644-5900
fax- 860-644-5978

Authorization for Use and Disclosure of Protected Health Information

Patient Printed Name:____________________Date of Birth:________________.

I authorize **Vipul Dua, MD** to release: (Please check one)

O All Records
O Portion of records concerning:________________________________

To: ____

Address:____

Fax # __________________or call when ready to pick up________________

The charge for copying medical records is $.65 per page plus the cost of first class postage. If special mailing is required, an additional charge of $15.00 will be assessed.____________initial

To the Patient: The information used or disclosed pursuant to this information may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. You have the right to revoke this authorization, so long as the release has not been completed. PL9-282 Sec. 52-146

This authorization, unless expressly revoked by earlier, ***expires six months from the date of this request.*** PL9-282 Sec 52-146.

If not signed by the patient, please indicate your relationship to the patient:

____**Date:**________
Patient Signature

Records Given/mailed/faxed: By:______________________________Date:__________.