Dr. Alka Singh, M.D.

Dr. Raja Singh, M.D.

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name: Social Security #: N/A

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I request and authorize Rejuvimed Wellness Center to release healthcare information of the patient named above to:

Facility/Physician:

Address:

Phone: Fax:

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This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

○ All healthcare information ○ Other

Additional Information:

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________________ Date signed: _________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.