SHAYONA ENT
H N S S D A
CLINIC, LTD.

JAY CHAVDA, M.D.P.A.

ENT HEAD/NECK SNORING ALLERGY
MEMORIAL HERMANN SOUTHWEST HOSPITAL
MEDICAL PLAZA - TWO
7737 SOUTHWEST FRWY SUITE 300 HOUSTON, TX 77074-1824 USA
PHONE: (713) 774-2090 • FAX: (713) 774-2096

Consent for Release of Medical Records to Dr. Jay Chavda

There could be a charge associated with each request. (Allow 7-10 working days for request to be processed. Patients 18 and over must sign their own release.) This consent will remain valid for 60 days unless a specific date/event is specified. Medical records from other facilities in our office will not be released. Please fill out form completely. If you do not receive records within 20 days you should call Medical records Department at (713-774-2090) EXT 112.

ACCT: _____ Patient Name: _____

DOB: ____/____/____ SS# ____-____-____ Phone #:____-____-____

Address: _____

Street City State Zip Code

I hereby authorize the office of: _____

Address: _____

Street City State Zip Code

Phone #:____-____-____ Fax#:____-____-____ To disclose information from the medical records.

I consent to have all the (or the following) medical information regarding my treatment and outpatient care released to: **Jay Chavda, M.D.P.A.** their address is **7737 Southwest Frwy Suite 300 Houston, TX 77074-1824 USA. Phone: (713) 774-2090 Fax: (713) 774-2096.**

Check all that apply:

- □ Treatment from: ____/____/____ To: ____/____/____.
- □ All Medical Records
- □ Laboratory Data Only
- □ X-Ray Data Only
- □Specific test: _____.
- □ Drug and alcohol related information
- □ Infection with human immunodeficiency virus information (HIV)

I permit this confidential information to be released for the following purpose:

- □ Continuation of Medical Treatment
- □ Litigation for review
- □Other: Specify Reason: _____.

Dr. Jay Chavda M.D., his employees and physicians are released form legal responsibilities or liabilities for the release of the above information to the extent indicated and authorized herein.

Print Patient's Name: _____.

Please attach a copy of patient's valid ID and power of attorney.

Signature of Patient or Legal Guardian: _____ Date: ____/____/____

This consent permits the practice to use and disclose my health information to carry out treatment, payment or health care operations. Additional information regarding the uses and disclosures of health information is described in the practice's "notice of privacy practices." This consent to release confidential information may be revoked by me in writing, at any time, I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS AND AGREE NOT TO SUE the Practice, its employees, and staff, in connection with the disclosure of my medical record.