Veena Vats, M.D.

3485 S Mercy Rd #104, Gilbert, AZ 85297
Phone: 480.558.3223 Fax: 480.558.5152

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Patient Name: ____ DOB: ______________

Date: ________________________

I hereby authorize:

Trinity ENT and Facial Aesthetics
Veena Vats, M.D.
3485 South Mercy Road, Suite 104
Gilbert, AZ 85297

To ☐ **release** or ☐ **obtain** copies of medical records concerning the above patient to:

Name: ____

Address: ____

City: ______________________________ State: ________ Zip Code: __________

Phone No: __________________________ Fax No: ______________________

The type and amount of information to be used or disclosed:

- ☐ Complete Medical Record
- ☐ Procedure/Biopsy Report
- ☐ Lab Results
- ☐ X-ray report
- ☐ Operative Report
- ☐ Other ____________________

I understand the information included in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency virus (HIV). It may also include information regarding behavioral or mental health services, and treatment for alcohol and/or drug abuse.

I understand that I may revoke this authorization at any time with a written request, except to the extent that action based on this authorization has already been taken.

This consent will expire automatically one year from the date on which it was signed.

X____ Date: ________________
Signature of patient or authorized guardian

X____ Date: ________________
Witness