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CONSENT TO RELEASE FORM

I, _____ HEREBY AUTHORIZE THE OFFICE OF:

DATED: _____.

To release medical information to and obtain information from:
ANY PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER PROVIDING MEDICAL CARE
TO ME ANY TIME.

- ** This authorization will expire one year from date of signature, unless otherwise specified* *
This consent may be revoked at any time by sending written notice to the above named provider of
information. Any release of information made prior to the revocation of this compliant authorization is not
breach of confidentiality. Disclosed information may be reviewed by contacting the provider of
information.

Patient's Name: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Complete Address: _____

Relationship, if not the patient: _____ Patient's Date of Birth: _____

I authorize these FAMILY MEMBERS/FRIENDS to have access to my medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

To the recipient of this information: This information has been disclosed to you from records protected by
the federal confidentiality rules. The federal rules prohibit you from making further disclosure without
additional consent.