Sujatha Borra MD., PA

Authorization to Release Medical Records

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/ person/facility/entity listed below:

Sujatha Borra, M.D., P.A.

13333 N 56th Street

Tampa, FL 33617

(813) 983-0894

(813) 983-0956 Fax

Patient Name _____

Patient Date of Birth _____

Signature of Patient or Personal Representative

Date _____

Print Name of Personal Representative _____

Description of Personal Representative Authority _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

Initial:_____ Date: _____

- ☐ Complete Records
- ☐ History/Progress Notes
- ☐ Care Plan
- ☐ Lab Reports/Radiology Reports/Pathology Reports
- ☐ Treatment Records
- ☐ Operative Reports/Hospital Reports
- ☐ Medication Record
- ☐ Other (Please Specify) _____

Request Release of my protected health information from the following physician/person/facility/entity:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____