RECORD RELEASE AUTHORIZATION

Nicole P. Singh, MD
OASIS INTERNAL MEDICINE, PLLC
1860 Town Center Drive
Suite 255
Reston, VA 20190
Phone: 703 707-0607 **Fax: 703 707-2027**

Patient Name:_____

Patient Address:_____

_____

Telephone: _____

Patient DOB: _____

_____X_____I hereby request my records be released to: Nicole P. Singh, MD

_____X_____ I request my records be sent to Oasis Internal Medicine PLLC at the above practice location from:

Entity Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Please send the following specific information:

_____ Hospital/Operative Records

_____ Laboratory Reports

_____ Radiologic Reports

_____ Office Notes

_____ All components of my record including the above and including mental health records, substance use treatment records, HIV information and genetic testing results

I understand that signing this authorization is voluntary. My treatment or eligibility for services will not be conditioned upon signing this form. I may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken in reliance upon it. Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy regulations. This authorization will expire one year from the date of signature unless otherwise requested in writing.

Signature:_____ (patient, legal guardian) **Date: _____**