Parag B. Thakkar MD SC
Internal Medicine & Primary Care
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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient: _____ **Date of Birth:** _____
(First Name) (Middle Initial) (Last Name)

Address: _____

Phone: _____ Email: _____

I authorize Parag B. Thakkar, MD SC to release/ mail a digital copy of my medical records to:

Recipient: _____

Address: _____

_____

Phone: _____ Fax:_____

For the Purpose of: Transfer of care to new provider due to closure of the practice.

I authorize release of medical records: including information and records or copies of records relating to the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychologist, if any.

I give permission to release all my medical records from 2013 to the present available in current EHR software at the practice (Records before 2013 are archived and can be requested for additional cost. Please contact my office in writing).

I release Parag B. Thakkar MD SC and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Parag B. Thakkar MD SC, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization. This Authorization expires on _____/_____/_____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if minor) Date

_____ _____
Witness Signature Date

Please mail this authorization along with a record release fee of $35 to the office address noted above before Sept 15th, 2024. After that date, mail to: Parag B. Thakkar MD SC, PO Box 7035 Libertyville IL 60048.