Manish Dixit, M.D., F.A.A.P.
1902 S. US Hwy 59, Suite 5
Parsons, KS 67357
(620)421-0002 phone
(888)820-2325 fax

Patient Name:_____ DOB:_____

Patient Address:_____

Hereby authorize: Doctor/Clinic _____

Phone # _____ Fax# _____ to disclose protected health information to:

Dr. M. Dixit, M.D. 1902 US Hwy 59, Suite5 Parsons, KS 67357

For the following purposes:
□ At the request of the patient/representative
□ Other: _____

Information to be disclosed:
□ Medical Records
□ Other: _____

This authorization expired _____

I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse. This information will be released unless objection is made by checking the statement below:

Do not release my health records pertaining to:

- □ Sexually transmitted disease
- □ AIDS
- □ HIV
- □ Mental Health Services
- □ Alcohol and/or drug abuse

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to M. Dixit LLC. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Signature of patient or representative: _____ Date:_____

Patient/representative (print): _____ Relationship:_____

Witness: _____

Verification of Information Released

Sent by mail on (date)_____

Faxed to (number) _____ on (date)_____

Sender's Initials _____