



CLERMONT
CARDIOLOGY

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AUTHORIZATION TO TRANSFER CONFIDENTIAL INFORMATION

I, _____, hereby authorize _____,
(individual, hospital, agency)

At _____
(address)

_____ (phone)

_____ (address)

_____ (fax)

to release my records to _____ at _____
(individual, hospital, agency) (phone)

_____ (address)

_____ (fax)

_____ (address)

I understand that this consent is revocable upon written notice to the above stated, except to the extent that action has already been taken on the authorization. Alcohol, drug, HIV, and/or AIDS information, if present, will be disclosed only if authorized. This information is confidentially protected by Federal Law, which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted such regulations.

(Patient's signature)

(Date of authorization)

(Social Security #)

(Date of Birth)