



Clary Document Management, Inc.
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____

Address: _____

Day Phone: _____

Email: _____

I request all medical records of the patient named above to be released from:

- Send all medical records to:
same address as above **\$10**
- or
- other address below **\$10**

**Dr. Desiraju, MD
2106 Hillcrest St
Orlando, FL 32803**

Name: _____

Address: _____

Year of Last Visit: _____

Reason for Release of Information:

Personal Use

Email: _____

Fax : _____

This request and authorization applies to all my medical records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether positive or negative) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management (Clary) receives my notice in writing submitted to the address above. I understand once Clary discloses my health information herein, it may no longer be protected by federal privacy laws.

I understand I will *pre-pay* a \$10 fee to reproduce medical records.

Patient Signature _____

Date _____

Patient Authorized Representative: _____

Date _____

Authority to Represent Patient: _____