

MALLIK THATIPELLI, MD

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Phone Number: Social Security#: to request and authorize release healthcare information of the patient named above to: Name: CALIFORNIA VASCULAR & VEIN CENTER Address: 2808 F Street, Suite A City: Bakersfield State: CA Zip Code: 93301 This request and authorization applies to: Healthcare information relating to the following treatment, condition, or dates: NEITHER TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS WILL BE CONDITIONED ON PROVIDING OR REFUSING TO PROVIDE THIS AUTHORIZATION THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY THE UNDERSIGNED MAY CANCEL THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A WRITTEN REQUEST TO MEDICAL RECORDS	Patient's	s Name:	Managant	Date of Birth:					
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	THE UNDERSIGNED MAY CANCEL THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A								
I UNDERSTAND THAT I MAY INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED									
Patient Date Signature: Signed:		e:							

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.