OPTIMUM MOA SERVICES, LLC.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Information Released From:

Name: Dr Ranjit Dedesma
Address: 100 Europa Dr Ste 360
City, State, and Zip: Chapel Hill NC 27517
Phone and Fax: 919-929-1227 / 919-968-2525

Information Release To:

Optimum MOA Services, LLC
1411 Queen Ann Street
Burlington, NC 27217
(T) 804-356-4744 (F) 866-355-8910

Reciprocal Authorization for Release of Information (Check if applicable)

____A mutual exchange of information may occur between Optimum MOA Services and the Individual or Group identified above.

Information to be Released (Please be specific)

____ Initial Evaluation ____ Office Visit Notes ____ Entire Record _____ Other

____ I understand that my medical record includes my personal information. All records are kept confidential and shared only with pertinent personal involved.

____ I understand the purpose of this release of records is for continuing treatment and for insurance purposes in regards to prior authorizations, referrals and recommendations.

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any medical personnel of the above entity or individual to disclose my protected health information as described on this form to Optimum MOA Services. I further understand that I retain the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. This authorization shall be valid for the duration of the patient's treatment at the above stated entity/individual or until rescinded in writing. I hereby release the above entity/individual from all legal responsibility or liability that may arise from this authorization.

_____ _____

Patient or Legal Guardian Signature Date Witness Signature Date

_____

Relationship to Patient

*By signing this form for someone else, you as the parent, guardian, or legal representative warrant that you have the legal authority to act on the patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.