Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

I authorize the practice below to release my health information:

Office Name: _____

Address: _____

Phone #: _____

Please forward/release my health information to:

Office Name: _____

Address: _____

Phone #: _____

Email: _____

The information below is provided at the request of the patient. Describe PHI (Protected Health Information) needed.

Xrays: _____

Other: _____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Dr. Suman Vidyarthi & Dr. Nanditha Vivekananthan.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct. 2012