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Patient Authorization For Use Or Disclosure of Protected Health Information

I authorize the use or disclosure of health information about me as described below:

I authorize _____ to release information from the
Name of practitioner or facility
medical records of _____.
Patient name – please print

To: _____
Person(s) or class of persons authorized to receive the information

_____
Address

_____
City, State. Zip code

Telephone Number: _____
Fax Number: _____

For treatment dates: _____
Required

Please indicate the information that may be used/disclosed:

_____ Entire Record Excluding HIV Testing
_____ Entire Record Including HIV Testing
_____ Progress Reports
_____ Lab Results
_____ Imaging/Radiology Reports
_____ Operative/Procedure Reports
_____ Other _____
Please specify

The information will be used or disclosed for the following purposes:

_____ At the request of patient _____ Legal
_____ Insurance _____ Inspection
_____ Other _____
Please specify

This authorization expires _____
Insert date

I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, that the information described above may be subject to re-disclosure by the recipient and no longer protected by these regulations. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance in this authorization.
I understand that I may refuse to sign this authorization and that my refusal to sign will not

affect my ability to obtain treatment or payment or my eligibility for benefits.

Date	Signature of Patient/Parent/Legal Guardian	Relationship to Patient

Fees and/or charges by Dr.Aruna Bakhru applicable to release of Protected Health Information will comply with all laws and regulations.