AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is to authorize the release of protected health information in accordance with the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/ or use of your health information.

Name of Patient:_____

Date of Birth:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the office of Dr. Maguluri and Dr. Ahuja to release my health information to:

_____
(persons/ organizations authorized to receive information)

PURPOSE

The purpose of the release of this information is for continuity of care.

MY RIGHTS

I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and no longer protected by the HIPAA Privacy rule.

SIGNATURES

_____
Patient or Legal Representative Signature/ Date