Authorization for Krishna M. Pinnamaneni, MD, MBA, MHSA, FRCP(C), FACP, FACE to Receive Healthcare Records

PLEASE READ CAREFULLY

Patient_____ Date of Birth_____-_____-_____

Address_____ Phone # (_____)_____

I hereby authorize:

_____ _____

_____ _____

to **provide records** concerning the above patient to be mailed to:

Krishna M. Pinnamaneni, MD, MBA, MHSA, FRCP(C), FACP, FACE
2034 E. Southern Avenue, Suite # T
Tempe, AZ 85282
P: (480) 838-2277
Visit: www.pinnamaneni.biz

PURPOSE OF RELEASE
( ) Appointment Date/ Continuation of Care:_____

MEDICAL RECORDS TO RECEIVE: (Check all that apply)

☐ Copy of medical records of the last ONE year of treatment received
☐ Copy of Office Notes
☐ Copy of Laboratory Reports
☐ Pathology Reports
☐ Radiology Reports

I authorize the release of photocopies of the following medical records in the possession or control to Dr. Krishna M. Pinnamaneni, their employees, and / or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. § 36-661).
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. § 36-661).
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ).
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS / TREATMENT INFORMATION.
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. § 12-2801).

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

SIGNATURE (required) **DATE (required) MM-DD-YYYY**

_____

Patient Signature Date

_____

Parent / Guardian / Power of Attorney Date