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

PLEASE READ CAREFULLY

(There may be a fee for copies of medical records.)

Patient Name ________________________ **Date of Birth** ______-______-______

I hereby authorize **Krishna M. Pinnamaneni MD, MBA, MHSA, FRCP(C), FACP, FACE** to **release** my medical records to:

Name of Authorized to Receive Records: ________________________Phone:______________

Address: ____

PURPOSE OF RELEASE

☐ Appointment Date / Continuation of Care:________________________________

MEDICAL RECORDS TO RELEASE: (Check all that apply)

☐ Copy of medical records of the last ONE year of treatment received

☐ Copy of Office Notes

☐ Copy of Laboratory Reports

I authorize the release of photocopies of the following medical records in the possession or control from 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**

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Patient Signature Date

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Parent / Guardian / Power of Attorney Date