SDMS, P.C.
Dr. Krishna Pinnamaneni
2034 E. Southern Ave., Suite T
Tempe, AZ 85282-7519

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize SDMS, P.C. to use and/or disclose certain protected information (PHI) about me to ______________________________________.
Name of entity to receive this information

This authorization permits SDMS, P.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

Medically pertinent

_________________________.

The information will be used or disclosed for the following purpose only:

For continuing health care to coordinate communication between healthcare providers

____.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 90 days from ______________.
Today's Date

The practice usually does not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, as long as accompanied by the patient (no telephone advice (or) non-medical information shall be given out).

I do not have to sign this authorization in order to receive treatment from SDMS, P.C. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the custodian of records at:

2034 E. Southern Avenue, Suite T, Tempe, AZ 85282-7519
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Signature: ____________________________ Date: ____________________

Print Name: ___________________________