SRILATHA REDDY, M.D. P.A.
FAMILY HEALTH & WELLNESS CENTER

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AUTHORIZATION FOR DISCLOSURE OF INFORMATION

PATIENT NAME: _____ BIRTH DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I HEREBY AUTHORIZE

_____

ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

THE INFORMATION TO BE DISCLOSED IS LIMITED TO (CHECK ITEMS)

__ Progress Notes __ Labs __ X-Ray/EKG __ Office Visits __ Hospital Visits
__ Treatment Notes __ other, specify _____

SPECIAL AUTHORIZATION FOR RELEASE OF RECORDS FOR MENTAL HEALTH/REHABILITATION, ALCOHOL OR DRUG ABUSE AND/OR DEPENDENCY, HIV ANTIBODY TESTS AND/OR AIDS DIAGNOSIS AND TREATMENT.

(Please initial if apply)

___ Include information related to diagnosis and/or treatment for alcoholism and/or drug abuse and or dependency.
___ Include information related to diagnosis and/or treatment for mental health/rehabilitation.
___ Include information related to HIV test results and/or AIDS diagnosis and treatment.

- A listing of the statutory exceptions to the release of HIV test results without consent is available.

Purpose or need of Disclosure

___ At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization.

I understand that I have the right to:

- Receive a copy of this authorization
- Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- Revoke this authorization, except on the extent that the person(s) and organization (s) listed above has already made in reference to this authorization.

Hereby release you, the physician, and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of this signature or automatically when the records/information requested on this form has been provided to the requestor.

_____ _____
Signature of Patient (Guardian) Date

_____ _____
Relationship of signed party Date

Prohibition of Re-disclosure: This information has been disclosed to you from the records whose confidentiality is protected by law. Any further disclosure is prohibited.