

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This document authorizes Dr. Prema Kothandaraman to release health information from the records of:

PATIENT NAME: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

TO: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Patient initials)

\_\_\_\_\_ I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

\_\_\_\_\_ I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Prema Kothandaraman.

\_\_\_\_\_ I understand that a revocation is not effective to the extent that Dr. Kothandaraman may have already disclosed the health information in accordance with previously signed authorizations.

\_\_\_\_\_ I understand that this authorization ends on \_\_\_\_\_ (date).

\_\_\_\_\_/\_\_\_\_\_

Patient or legal representative signature/date

Patient Representative: Parent/Guardian of minor patient

Guardian/conservator

Next of Kin/Executor of Deceased

(office staff initial)

\_\_\_\_\_ copy given to patient/legal representative

\_\_\_\_\_ original placed in medical record