

This form needs to be filled out if a family member or friend were to call the office on your behalf – with this form filled out Dr. Ragupathi & staff have been given your permission to speak with them. If you would prefer Dr. Ragupathi & staff only speak with you please check the box that is provided and sign where your signature is required.

Authorization For Release Of Information

(Authorization of Information to family member / close friend)

I hereby authorize Dr. Kuppasamy Ragupathi & staff to disclose my individually identifiable health information as described below, including but not limited to information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that the recipient authorized to receive the information is not a health plan or healthcare provider, and released information may no longer be protected by federal and state privacy regulations.

Print Patient Name

Date of Birth

Social Security #

Description of information to be released: (check all that apply) : _____ ALL
____ Physician Order _____ Consultation Reports _____ Progress Notes
____ Admission Records _____ Operative Reports
____ Discharge Summary _____ Radiology Reports _____ Billing Records

The health information described herein shall be released to:

Name

Address

City

State

Zip

Phone number

Relationship to patient

OR

- DO NOT release my medical information to any family member or friend.
No one will be calling the office on my behalf other than myself.

I understand that this authorization will expire 180 days from the date of this authorization unless otherwise specified: _____, whichever occurs first.

I further understand that I may revoke this authorization at any time by notifying Dr. Kuppasamy Ragupathi in writing to 1602 Rock Prairie Rd Ste 200 CS, TX 77845. I also understand that the written revocation must be dated with a date that is later than the date on this authorization and signed. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient

Date

Date of Expiration: _____

Office Personnel Initials: _____