

Priya Tandon MD, LLC
123 Broadway Street
Colchester, CT 06415
Tel 860-537-2309
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Authorization Form for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ Date of Birth: ____/____/____

I hereby authorize _____ to use and/or disclose the Protected Health Information described below to Priya Tandon, MD, LLC (please mail or fax to address/fax number above)

Dates of Medical Care

All Dates of Care Dates of Care to include: _____

Purpose of this disclosure

Worker's Comp Attorney Personal Other _____
 Transfer of Care Referral Consultation Billing/Insurance

Information to be Disclosed

Entire Record EKG Laboratory Reports Diagnostic Reports
 Immunizations Other Pap Smear Report:

Information you wish NOT TO BE DISCLOSED relating to:

Drug and/or Alcohol testing and treatment Human Immunodeficiency (HIV) Virus test results
 Mental Health Records

If you are not the patient, please indicate your authority to act on behalf of the patient (Please attach proof).

Parent Durable Power of Attorney for Health Care
 Legally Authorized Representative Other (please specify) _____

I understand that I may inspect or obtain a copy of the protected health information described by this authorization. I understand that Priya Tandon, MD, LLC will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Priya Tandon, MD, LLC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. COPY PROVIDED: Priya Tandon, MD, LLC shall provide a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains. Connecticut state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the above medical information that may be held by Priya Tandon, MD, LLC: information pertaining to my HIV status and records of care and treatment for HIV/AIDS, records of mental health care and treatment and records of substance abuse care and treatment.

In addition, PRIYA TANDON, MD, has provided me with an office copy of their PRIVACY PRACTICE NOTIFICATION that describes how medical information about me may be used and disclosed and how I can access this information in accordance with HIPAA federal guidelines. I acknowledge that I have been given the office copy of the Privacy Notice and have been offered a personal copy if so desired.

EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____, or the following event: _____ (If no date is stated, this authorization expires one year from the date it was signed).

Signature of individual patient or Authorized Representative Authority or Relationship Date