Priya Tandon MD, LLC

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Authorization Form for Use and Disclosure of Protected Health Information

Patients 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 Case to Include_____

Purpose of this Disclosure

___Worker's Comp ___Attorney ___ Personal ___ Other_____

___Transfer of Care ___Referral ___Constultation ___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 Virus Test Results

___Mental Health Records

If you are not 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 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 reference on an authorization I have signed. I understand that information used or discussed 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 consent of the person to whom it pertains. Connecticut state law requires an individual or the individuals 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 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 in accordance with HIPAA federal guidelines. I acknowledge that I have been given the office copy of the Privacy Notice and have been offered and have been offered a personal copy if so desired.

EXPERATION DATE OR EVENT: This authorization will expire on (date no later than one year from now)_____ or the following event_____(if no date is state, this authorization expires one year from the date it was signed).

_____	_____	_____
Signature of Individual Patient or Authorized Representative	Authority or Relationship	Date