

Medical Records Release

Name: _____ DOB: _____

I authorize the release of, or request access to the information specified below from my medical records.

Reason for information needed:

Transfer of care

Continuation of care

Information to be released:

All dates of care

Date(s) to be included

Other

Information may be released to:

From:

Priya Tandon MD, LLC
7 Park Ave, Suite 1
Colchester, CT 06415
Phone: 860-537-2309
Fax: 888-297-2226

I understand that my records are confidential and cannot be released without my written consent, accept otherwise permitted by law.

I understand that the specified information to be released may include but is not limited to history, diagnoses and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV/AIDS.

I understand that I may revoke my request in writing at any time except to the extent that action has been taken in reliance upon authorization.

This authorization will expire in 1 year from the signature date.

Date: _____ Signature: _____

Patient/Parent/Authorized Rep
Name of Authorized Rep:

Priya Tandon MD, LLC

7 Park Ave, Suite 1
Colchester, CT 06415

Statement of Financial Responsibility:

The office of Priya Tandon MD, LLC will verify your insurance coverage and bill the insurance carrier(s) on your behalf. **You are responsible for payment of any deductible, copayment or coinsurance at the time of service.** Please be aware that some insurance plans cover a physical exam in full however you may be responsible for a copayment, deductible, or coinsurance if they decide that something other than wellness issues were discussed.

Balances must be paid in full at time of service this includes any deductible, coinsurances, and copayments. The office would be happy to work with you in arranging a payment plan if needed.

Signing this you agree to full payment of financial responsibility your insurance does not cover.

Signature: _____

Date: _____

No Show, Late, and Cancellation Policy:

We schedule our appointments so that each patient receives the right amount of time with Dr. Tandon. That is why it is very important to keep your scheduled appointment with us and arrive on time.

As a courtesy we remind patients 2 business days in advance of their appointment. If you cannot make your appointment, **please contact the office 24 hours in advance so we can reschedule you, and accommodate those patients who are waiting for an appointment.**

If you do not reschedule or cancel your appointment within 24 hours there will be a fee assessed.

By signing this you agree to cancel or reschedule your appointment at least 24 hours in advance. If less than the 24 hours a fee will be assessed to you.

Signature: _____

Date: _____

Priya Tandon MD, LLC

7 Park Ave, Suite 1
Colchester, CT 06415

The federal government requires medical offices to make all patients aware that they have rights regarding the use of their personal health information. A copy of this Notice of Privacy Practices is available for you at the front desk. We are providing this form to comply with the Health Insurance Portability Act of 1996. (HIPAA)

By signing this form you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices. You have the right to revoke this at any time, in writing. However, such revocation will not affect any disclosures we have already made in reliance on your prior consent. You have a right to request a restriction or limitation on medical information we use or disclose about you for your treatment, payment, or healthcare operation, this request must be done in writing.

The patient understands that Priya Tandon MD

- * Will not disclose any information to future doctor, attorney, life insurance Company, and workman's Compensation Company without written consent.
- * Protected health information may be used for treatment through your current doctors, payment with your insurance company, or healthcare operations within this office.
- * The practice has a copy of the Notice of Privacy Practices that the patient may review at any time.
- * The practice has the right to change the Notice of Privacy Practices
- * The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- *The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- *The practice may condition receipt of treatment upon the execution of this consent

Signature: _____

Date: _____