12602 Toepperwein Rd, Suite 114
San Antonio Texas 78233
(210)655-0075

AUTHORIZATION TO USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION

Patients Name | Date of Birth | SSN

By signing this form I authorize: **To release to :**

Rohit Kapoor MD PA
12602 Toepperwein Suite 114
San Antonio, Texas 78233
Tel # (210)655-0075
Fax #(210)655-2117

Name :
Address :
Phone :

The following individually identifiable health information about me: (Specifically describe the information to be used or disclosed, such as date(s) of services, level of detail to be released, origin of information, etc):

☒ All Medical Information ☐ Radiology Reports ☐ Laboratory Results
☐ Progress Notes ☐ Operative Report ☐ Insurance Information
☐ Other

Covering the period(s) of care from **to**

I understand that the information relevant to HIV and testing and/or AIDS related diagnostic(es) may be contained in the information. I understand this information may also include references to psychiatric treatment or treatment for substance abuse.

The information will be used or disclosed for the following purpose(s):

☐ At the request of the individual ☐ Continued Treatment ☐ Insurance
☐ Legal ☐ Other

The authorization will expire on: **Not to exceed 24 months**

I understand I have the right to inspect and copy my own protected health information to be used or disclosed under this authorization. Rohit Kapoor MD PA will not receive payment or other remuneration from a third party in exchange for using or disclosing this information. I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I also understand that I do have to sign this authorization in order to receive treatment information from Rohit Kapoor MD PA. In face I have the right to refuse to sign this authorization. When my information is used to disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Rohit Kapoor MD PA has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address above

Signature of Patient or Legal Gaurdian **Relationship to Patient (If guardian)**

Printed Name of Patient or Legal Guardian **Date Signed**