Authorization to Release Health Information

This form authorizes Kumkum Patel MD, Inc. - A Medical Corporation to discuss and exchange medical information about you and your care and treatment to you, and to those you list on this form.

COMMUNICATING WITH YOU – DETAILED MESSAGES PERMITTED

Detailed messages may include the following information: (check all that apply)

□ All information from this practice

□ Billing/Insurance information

□ Appointment information only (request/confirm/cancel)

□ Data breach notifications

Phone #: _____ □ Text (SMS)* □ Voicemail

Other #: _____ □ Text (SMS)* □ Voicemail

□ Email (address) _____

NOTE: I understand that emails and texts are not always secure ways to communicate and can be intercepted and read by a third party. I am willing to accept this risk. This medical practice is not responsible for the privacy or security of your health information once it is transmitted to you, or the recipient(s) listed below.

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

This practice may communicate to the family members, friends, or caregivers listed below.

Name: _____
Phone: _____
Email: _____
Relationship: _____

Name: _____
Phone: _____
Email: _____
Relationship: _____

Check the box next to each type of information this practice may share with the individuals listed above.

□ Any of your Health information □ Appointments □ Billing/Insurance □ Other (SPECIFY) _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our "Notice of Private Practice" form for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- All changes or updates to information that you have provided this form must be made in writing and signed by you (patient) or your personal representative.
- Minor edits can be made on this form, initialed, and dated in lieu of preparing a new form.
- This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- This practice made the Notice of Privacy Practices form available for my review. I have read and understand my privacy rights.
- By signing this consent, I give my permission for you to access my Health Information from my Primary Care Provider (PCP), as well as any and all health Insurance information as needed by this practice upon my behalf.

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Printed Name Patient's Date of birth

(Attach documentation to support the personal representative's authority if not already on file with the practice)