AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **DOB:** _____

MY AUTHORIZATION:

I hereby authorize **Mahipal S. Chaudhri, M.D, psychiatrist** and associated employees, agents, contractors, or affiliates entrusted with handling medical records to obtain and give my protected health information to the following:

Circle one: (Specialist/Therapist/Primary Care Physician/Nurse Practitioner/School/Other)
Name:
Address (if known)
Phone (if known)
Fax (if known)

For the full purpose of chemical dependency and psychiatric evaluation / care and also related issues such as financial, billing, educational, work disability, medical leave & others

PLEASE INITIAL ALL THAT APPLIES

___ **all my health information**

___ health information for the following dates _____

___ health information related to the following conditions _____

___ other: _____

This authorization shall remain in effect

___ until termination of treatment with **Dr. Chaudhri or**

___ the following date _____

MY RIGHTS

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to Mahipal S. Chaudhri, MD. 890 Westfall Rd., Suite B, Rochester, NY 14618.

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I understand that the revocation of this authorization is not effective to the extent that the Provider has relied upon it for the use or disclosure of the Protected Health Information prior to receiving my written revocation notice.

I understand that any Protected Health Information disclosed pursuant to this authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I acknowledge that the Provider will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I sign this authorization, unless: (a) the treatment being provided is research-related and the Protected Health Information is to be used for that research; or (b) the health care the Provider is providing is being provided solely for the purpose of providing the Protected Health Information to a third-party.

_____ _____

Date Signature of Patient or Personal representative

_____

Description of Personal Representative's Authority

A SIGNED COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT OR THE PATIENT'S REPRESENTATIVE UPON REQUEST

Please return to: Mahipal S. Chaudhri, M.D.
890 Westfall Rd., Suite B
Rochester, NY 14618
Phone: 585-442-6960 FAX: 585-442-3548