Priti M Kothari, M.D., P.A.
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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

Phone#: _____

By signing this authorization, I authorize Dr. Priti Kothari to use and/or disclose certain protected health information (PHI) about:

Patient's Name" _____ to

Name of Individual/Group/Agency/Hospital/etc.: _____

Address: _____

Phone/Fax: _____

This authorization permits Dr. Kothari, M.D., to use and/or disclose to or obtain from other designated party listed above, specified individually identifiable health information about the above-named patient including but not limited to medical records, reports, and progress notes related to diagnoses, comprehensive medical history, drug and alcohol abuse history and treatment, legal history, HIV status and /or treatment, history of sexually transmitted diseases, treatment plan, and prognosis. Additional information may include the following: laboratory and imaging results, report cards, progress reports, educational testing, direct interview and any other information deemed appropriate by the specified individuals contacted and/or Dr. Kothari. .

The information will be used or disclosed for the of continuity of care, diagnosis, and direct treatment planning. The purposes are provided so that I can make an informed decision whether to allow a release of the information. This authorization will only expire by written consent or formal termination of treatment. My written revocation must be submitted directly to Dr. Priti Kothari. I do not

have to sign this authorization in order to receive treatment from Dr. Priti Kothari. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Priti M. Kothari, M.D. from any and all liability that may arise from the release of information as I have directed.

Signature of Patient or Legal Guardian: _____

Relationship to Patient: _____

Date: _____

Witness: _____ Date: _____