

HIPAA RELEASE AND AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

Medical Records. I hereby authorize GIA/TDDC/DHAT ("Releasor") to use or disclose the following: (check one)

- **ALL Medical Records**. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

Restrictions - Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

- Be Included.

- NOT Be Included.

- **Specific Medical Records:** _____

Recipient. My medical records shall be disclosed to the following individual or entity:

Name: Yamini Maddala, M.D. | DHPT Contact: Tammy Wortham

Address: 210 S Preston Road, #30, Prosper TX 75078 Phone: 972-408-4400

E-Mail: tammy.wortham#dhptx.com Fax: 908-408-4422

Purpose of Release: Transfer of care from GIA to Dr. Maddala

Expiration. This authorization expires on: No Expiration Date

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient or Personal Representative Signature

Date

Printed Name

Personal Representative Relationship to Patient

Email Address _____

Cell _____