

# T & K PHYSICIAN ASSOCIATES, LLC

Kumar Sathianathan, MD

Tony Shallin, MD

## Authorization for Release of Medical Information

I hereby authorize the following information be released from the medical record of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Soc. Security #: \_\_\_\_\_

### PLEASE CHECK INFORMATION REQUIRED TO BE RELEASED

Clinic Notes       History & Physical       Mammogram Reports       Emergency Room Record  
 Progress Notes       Discharge Summary       Billing       Lab Report  
 EKG, EEG, EMG       Directive to Physician       X-Ray Report       Operative Report  
 Pathology Report       Immunization Record       Other: \_\_\_\_\_

### PURPOSE OF DISCLOSURE

Attorney/Legal       Continued Patient Care       Personal Use (at the request of the individual)  
 Commercial Insurance       Worker's Compensation       Other (specify): \_\_\_\_\_

### This information is to be released:

**TO: T & K Physician Associates, LLC**  
**Address: 3613 Williams Dr. #404**  
**Georgetown, TX 78628**  
**Phone: (512) 930-4275 ext. 28**  
**Fax: (512) 930-4093**

**FROM:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
\_\_\_\_\_  
**Phone#:** \_\_\_\_\_  
**Fax#:** \_\_\_\_\_  
**Email:** \_\_\_\_\_

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient. I understand that I may revoke this authorization in writing at any time except the extent that Physician Associates has already released on this authorization. I understand that I may revoke this authorization by providing Physician Associates Privacy Officer a written request for revocation stating my intent to do so. If information is being released directly to me, I understand that my medical records may contain reports, tests, results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

This authorization will expire in 365 days, or at the date or event specified here \_\_\_\_\_ . I understand that the information released is for the specific purposes stated above and may not be provided in whole or in part to any other agency, organization, or person.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative's Authority to Act for Patient

\_\_\_\_\_  
Witness