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:

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

TO: _____
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 T&K Physician Associates has already released on this authorization. I understand that I may revoke this authorization by providing T&K 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. I will not hold T&K Physician Associates liable for any misinterpretation of the information that has been written in the record as a result of not consulting my physician for the correct information.

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**