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.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Representative's Authority to Act for Patient **Witness**