Authorization for Dr. Krishna M. Pinnamaneni to Receive Records

PLEASE READ CAREFULLY.

Do NOT Fax Medical Records

(There may be a fee for copies of medical records)

Patient_____ Social Security #_____ - _____ - _____

Address_____ Date of Birth_____ - _____ - _____

_____ Phone # (_____) _____

City State Zip

I hereby authorize **Dr.** _____ to **provide records** concerning the above patient to be mailed to:

Please send records to: Krishna M. Pinnamaneni, MD
2034 E. Southern Ave., Ste. T
Tempe, AZ 85282
(480) 838-2277

PURPOSE OF RELEASE

( ) Appointment / Continuation of Care:_____
Appointment Date

MEDICAL RECORDS

( ) Copy of medical records of the last two years of treatment received.
( ) Copy of medical records covering from: _____ to _____
( ) X-Ray, EKG, Lab Reports: _____ to _____
( ) Other_____

I authorize the release of photocopies of the following medical records in the possession or control to Dr. Krishna M. Pinnamaneni, their employees, and / or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. § 36-661).
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. § 36-661).
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ).
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS / TREATMENT INFORMATION.
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. § 12-2801).

This content will expire ninety days (90) after the signed date below. I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization at any time providing I notify Dr. Krishna M. Pinnamaneni, in writing, to that effect. I understand that any releases that are made prior to my revocation, in compliance of a photocopy / facsimile of this authorization are considered acceptable in lien of the original.

_____

Patient Signature Date

_____

Parent / Guardian / Power of Attorney Date