Authorization For Release of Information

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulates how your protected Health Information (PHI) is "Used and Disclosed". The regulations are being enforced to protect your privacy, and Uma Sundaram, M.D. is committed in complying with all applicable laws and regulations. By checking the appropriate lines below, you are allowing Uma Sundaram, M.D. to release limited health care information. You may revoke this consent at any time, in writing, to our facility.

I, _____ give my consent to Uma Sundaram, M.D. to

speak with family members/spouse regarding office visits, procedures, appointment scheduling, collection of demographic information, and insurance billing requirements or billing inquiries. Please list all person(s) whom we are to release this information to, and their relation to you:

_____

_____

_____

_____ _____

Print Patient Name or Legal Representative Signature

_____ _____

Date Witness/Office Staff Signature

Please note, all requests for disclosure of medical records outside of our facility to anyone other than the referring physician, will require the patient to complete and sign an "Authorization for Health Information Disclosure" form.

Please complete assignment of benefits on reverse side of this form.