SUDHA KARUPAIAH, M.D. PC
Sudha Karupaiah, M.D.
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY &/OR OTHERS

I hereby authorize Sudha Karupaiah, M.D to release my patient information* to the family members and others listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that the Health Information Portability and Accountability Act of 1996, and its implementing regulations (HIPAA) govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to the attention of "The Compliance Officer". I understand that I am not required to sign this Authorization and that SUDHA KARUPAIAH MD PC may not condition treatment on my execution of this Authorization. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization. I hereby acknowledge receipt of this Authorization.

I DO / DO NOT GIVE PERMISSION (Circle One) to Sudha Karupaiah, M.D. to leave information on my answering machine/voice mail and with my family members in regards to appointments, referrals and test results.

*****Information/documents regarding medical treatment of the patient including diagnosis, procedures and test results

_____ Please initial for permission to share immunization information with other providers.

Signature of Patient or Patient Representative (Legal): _____

Date Authorized: _____

Signed copy given to patient by officer epresentative: YES / NO Initials: _____ Date: _____

Copy to be entered into patients Electronic Health Record