

RAJIV JOSEPH, M.D., Ph.D.
Fellow, American Academy of Neurology
Board Certified in Neurology & Clinical Neurophysiology

Phone: 972-712-4141

7920 Preston Rd. Ste 100, Plano TX 75024

Fax: 972-712-4555

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
FROM DR RAJIV JOSEPH

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record No# _____

Date of Birth _____ Social Security# _____

I authorize the following individual or organization to disclose the above named individual's health information:

RAJIV JOSEPH, M.D., Ph.D.

Address: 7920 Preston Rd. Ste 100
Plano, Texas 75024

Phone: 972-712-4141
Fax: 972-712-4555

This information may be disclosed TO and used by the following individual or organization:

_____ Phone: _____ Fax: _____

For the purpose of: _____

_____ Progress Notes _____ History/Physical Exam
_____ Lab Results _____ List of Allergies
_____ Other Diagnostic Reports (Specify) _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Joseph.

I understand that my medical records may contain reports, test 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 contained in these entries. I will not hold Sleep Disorders Clinic of Dallas or Dr. Rajiv. Joseph liable on any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness