

RAJIV JOSEPH, M.D., Ph.D.
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Phone 972-712-4141

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
TO DR. RAJIV JOSEPH.

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

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____

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

Name: _____ Address: _____
Phone: _____ Fax: _____

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

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

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

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

For the purpose of: _____

Please release the following:

_____ 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.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness