Patient Authorization for Nishant R. Patel, MD, PLLC to Release Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose:

____ Collaboration in assessment & treatment (including history, diagnosis, treatments, etc.)

____ Other (specify, e.g. transfer of care):

Individuals who may **disclose** and use this information:

____ Nishant Patel, MD (11201 SE 8th Street, Ste 105, Bellevue, WA 98004; practice closure on June 28, 2019)

____ Other (specify):

Individuals who may **receive** and use the disclosed information:

____ Nishant Patel, MD

____ Other (specify, including phone and fax numbers):

The following authorized disclosures are **included** *unless* marked (*please initial if **excluding** authorization*):

_____ Mental Health _____ Alcohol/Substance Diagnosis or Treatment _____HIV/AIDS/STD

Expiration date of this authorization: 1 year from date of signature (unless otherwise specified: _____)

The above-mentioned Protected Health Information may be subject to redisclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by: _____ _____

Printed Name – Patient or Representative (specify relationship) DOB

_____ _____

Patient or Representative Signature Date