PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Referral to Specialist

I, _____, understand that as part of my treatment, Amod P. Paranjpe DPM has determined I should visit a specialist or other physician. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Advanced Podiatry, LLC to release or disclose my protected health information to the specialist or other medical practice named below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply)

__ The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed)

__ The patient's demographic information (check all that apply)

__ Name __Address __State/Zip code only __ Telephone

__ Age __Gender __Race __Other_____

__ Medical Data/Information as related to :

__ Specific condition(s): _____

__ Specific professional service(s): _____

__ Specific medication(s): _____

__ Other: _____

__ Other: _____

_____

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:

_____

Name of specialist or other medical practice, address, and fax number:

_____

_____

_____

Amod P. Paranjpe DPM shall send information ONLY to the above address or fax number. Any disclosure of the patient's protected health information to another address or fax number will require a separate authorization.