Rakesh K Saini, MD
3600 South Cooper St, Suite 100
Arlington, Texas 76015
(817) 419-6200 Office
(817) 419-6201 Fax

HIPAA: Patient Release of Personal Health Records

Patient Name: _____ Date of Birth _____
Patient Phone Number: _____

1. **Please release the requested information:**

TO: __Rakesh K Saini, MD_____ FROM: _____
Address: _3600 South Cooper St # 100_____ Address:_____
Phone: _817-419-6200_____ Phone: _____
Fax: ___817-419-6201_____ Fax: _____

2. **Reason for Release**: _____
3. **Dates of Treatment: All: _____ or** from: _____ To: _____

4 **Specific reports to be disclosed**:
Entire Health Records for past two years (unless otherwise specified) Other _____

I give specific authorization to disclose the following information:

- ❑ HIV test results
- ❑ Drug and alcohol abuse treatment records
- ❑ Documentation of AIDS diagnosis
- ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Kristi, privacy officer in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations. Unless revoked earlier, this authorization does not expire.
I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient

To the party receiving this information: Information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits from making any further disclosure of it without specific written consent of the person to who it pertains, other information is not sufficient for this purpose. For Patient Records Applicable Under Federal Law 42 CFR Part 2.