TJ RAI, MD
THERAPY MEDICINE WELLNESS

Authorization for Exchange of Information

I hereby authorize Tejinderpal S. Rai, M.D. to: ❑ release and receive ❑ receive ❑ release information regarding

_____ DOB: _____/_____/_____ SSN: _____-_____-_____ to/from:
FIRST NAME *MIDDLE INITIAL* *LAST NAME*

_____

_____

_____

Information exchanged shall include Medical treatment, Mental health treatment, Substance abuse treatment, Psychological / Vocational / Speech and Language Testing results, School records / Academic Testing results / Occupational evaluation or records, Lab test results including HIV / Alcohol and Drug Testing / Radiologic Studies / EEG reports, Family history and any other clinically relevant information.

Treatment may not be conditioned on signing this authorization, except if authorization is to determine an entity's obligation to pay a claim, or to create health information to provide to a third party.

I understand that if I have authorized disclosure of information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

This consent authorizes verbal discussion of information and exchange of written information.

This authorization is valid for one year from the date of signature, unless revoked earlier.

This authorization is voluntary and can be revoked at any time by signing the bottom of this form.

I have a right to receive a copy of this authorization.

Purpose of authorization: ❑ Coordination of treatment ❑ Patient request ❑ _____

Specific Info requested: ❑ Evaluation ❑ Discharge summary ❑ Lab tests ❑ Entire record ❑ _____

_____

_____ _____
PATIENT SIGNATURE *DATE* *RESPONSIBLE PARTY SIGNATURE* *DATE*

Witness: _____ _____
Tejinderpal S. Rai, M.D. *IF SIGNED BY RESPONSIBLE PARTY, PRINT NAME (AND RELATIONSHIP TO PATIENT)*

REVOCATION OF AUTHORIZATION

As of this date, I _____
PRINT NAME OF PATIENT OR RESPONSIBLE PARTY *(IF RESPONSIBLE PARTY , STATE RELATIONSHIP TO PATIENT)*
revoke the above authorization for exchange of information.

_____
SIGNATURE *DATE*