HERCHARAN SETHI, M.D.
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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Hercharan Sethi, M.D. to use or disclose to:

Name of person(s)	Relation to me	Specify disclosure(s)

The following individually identifiable health information: test results; social, mental & physical health; appointment information; billing (and/or billing related account information); complete history and physical information; social, mental, physical, demographic information, etc. If you would like us to disclose complete information from your medical records then please write "complete" under the disclosure column.

_____ authorization to allow verbal messages with contact name and telephone number(s) on recording devices connected to patient telephone system. (initial to allow such messages)

This authorization will expire on _____. (write "indefinite" if no end date applies)

When my 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 by the federal HIPAA Privacy Rule.

By signing this form, I am consenting to Hercharan Sethi, M.D. use and disclosure of my PHI to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hercharan Sethi, M.D. may decline to provide treatment to me.

_____	_____	_____
Print name of patient/ Guardian	Signature	Date

Patient's Name: _____