Sunita Swamy MD PA
PH: 512.394.7377

1600 W 38TH Ste 406
Austin, TX 78731

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Dr. Sunita Swamy to verbally release my confidential health information to the person(s) or entity(ies) listed below.

Information regarding person or entity who can receive this information:

Full Name: _____ Date of Birth: _____

Address:_____ City:_____ State:____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding person or entity who can receive this information:

Full Name: _____ Date of Birth: _____

Address:_____ City:_____ State:____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding person or entity who can receive this information:

Full Name: _____ Date of Birth: _____

Address:_____ City:_____ State:____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Do Not Include the following:
(*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

_____ X-Ray Results

_____ Lab Results

_____ Referral Information

_____ Medications

Other:_____

I Do Not Want my confidential health information to be disclosed.	**Signature:** _____

Initial_____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider as addressed below and I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Privacy Officer
1600 W 38TH ST Ste 406
Austin, TX 78731

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** unless I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I have not initialed the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws

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SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

Initial_____