TJ RAI, M.D.

THERAPY | MEDICATION | 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:
LAST NAME FIRST NAME MIDDLE INITIAL

____

____

____

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

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