



Anant Kumar, MD, MS

*Medical Information Release Form
(HIPAA Release Form)*

Name: _____ Date of Birth: ____/____/____

Patient Disclosure Record

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Initials (I have read the above policy)

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____
- Information is *NOT* to be released to anyone.

Contact Information

Please call:

- Cell number
- Home number
- Work number

If unable to reach me:

- Leave a detailed message
- Leave a message asking me to return your call
- _____

Written Correspondence:

- Home address
- Work address

This *Release of Information* will remain in effect until terminated by me in writing.

Signed: _____ Date: _____