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HIPAA Privacy Authorization Form

To our valued patients:

We strive to achieve the highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of Personal Health Information (PHI) following governmental rules, regulations, and laws. We want to ensure that our practice never contributes to the growing improper disclosure of PHI. As part of this plan, we have implemented a compliance program to help us prevent any inappropriate use of PHI. Do you have the right to review our privacy notice, request restrictions, and revoke the consent in writing after you have reviewed our privacy notice?

I authorize DMV Allergy and Asthma Center to use and disclose my PHI to the following individuals:

- Any member of my family
- Only with the following individuals:
- I do not permit to share any of my medical information

The authorization for the release of information covers the period of healthcare from:

- Until canceled by me in writing
- From _____ to _____

The person may use this medical information for medical treatment or consultation, billing, claim payments, or other purposes I may direct. I understand that I have the right to revoke this authorization in writing at any time.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information disclosed according to this authorization may be disclosed by the recipient and no longer protected by federal or state law.

Patient Name and/or Authorized Representative: _____

Relationship to Patient: _____

Patient Signature and or Authorized Representative: _____

Date signed: _____