VINU GANTI, M.D., P.C.

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

NOT TO BE USED IN CONNECTION WITH HEALTH INFORMATION FROM SUBSTANCE ABUSE TREATMENT OR MENTAL HEALTH PROGRAMS.

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

Patient Name:

(firstName)_____(m.initial)_____

(last Name)_____

Address: (street address)_____

(city)_____ (State)_____ (zip code)_____

Birth Date:_____

For this authorization, "My Health Information" means any and all information relating to my course of examination and

Treatment.

I authorize Vinu Ganti, M.D, P.C. to discuss My Health Information with:

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone #:_____ Phone #:_____

For general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matter.

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, **Vinu Ganti, M.D, P.C**. will not disclose My Health Information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here:_____. I may revoke this authorization at any time in writing by mailing or faxing my written request along with a copy of the original authorization to the clinic or department where my authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of patient only:_____ **Date(required**)_____

If you are NOT the patient but are signing on behalf of patient complete the following:

I, (print your name)_____, confirm that I am the legally appointed representative for the patient and I have mention my relationship to the patient below:

Relationship to Patient:_____