PHOENIX MEDICAL ASSOCIATES
ANAND MEHENDALE M.D.
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AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM PHOENIX MEDICAL ASSOCIATES

I, _____(DOB:_____), hereby authorize the following physician and/or practice:

Anand Mehendale MD of Phoenix Medical Associates ("practice") to disclose the protected health information described below for the following purpose(s)

- **Ongoing Medical Care.**

This disclosure will be made by the office staff of this practice.

The health information to be used and/or disclosed is specifically described as follows:

- **History and Physical Examination**
- **Radiology and Laboratory Reports**
- **Progress Notes**
- **Discharge Summary**
- **Psychiatric/Psychological Evaluation/s**
- **Medical Records pertaining to Addictive disorders**
- **HIV Testing and Treatment**

The person or class of persons to whom the information will be disclosed or who will use the information is:

_____

The practice is hereby authorized to make the disclosure to these classes of persons and the aforementioned classes of persons are hereby authorized to use or disclosed the information.

This authorization shall be in force and effective until the following event and/or date:

- **1 year from the date of execution of this document .**

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Anand Mehendale MD of Phoenix Medical Associates at 222 Sidney Baker South Suite 500 Kerrville, Texas 78028.** I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority