Pradeep Kumar, MD
3900 w. 15th Street, Suite 305
Plano, TX 75075
Phone 972-849-9597 Fax: 972-596-8157.

Name: _____
Date of Birth_____

I hereby authorize Dr. Pradeep Kumar to: **Obtain Protected Health Information**
Release Protected Health Information

Name of person or Entity_____
Address_____
Phone Number_____
Fax Number_____

The information may be used or disclosed includes:
Check applicable one: Diagnosis Psychiatric Evaluation Progress Note
Others_____

In addition I authorize Dr. Pradeep Kumar to: Obtain/ Release Protected Health Information Regarding:
Substance Abuse HIV/ AIDS
For the purpose of: Circle one
Evaluation Treatment Legal Other: _____

I am the person whose records will be used or disclosed. I understand and agree to this authorization.
Signature_____ Date_____

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is _____. I understand and agree to this authorization.

_____, _____.
Signature Date

This authorization expires on _____.
It is understood that this authorization may be revoked. Information disclosed before an authorization is revoked may not be retrieved. If action was taken in reliance on the authorization, the person who relied on the authorization may continue to use or disclose protected health information as needed the work that because the authorization was given.

I hereby revoke this authorization dated_____, permitting use and disclosure of protected health information in the manner described in this authorization.

_____ _____
Signature of the person self/parent/guardian Date

Note: A photocopy or facsimile of this authorization shall be as effective as the original.