Allergy, Asthma, & Pulmonary Clinic
Sleep Diagnostic Centers
Kris Bhat, M.D.

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AUTHORIZATION TO RELEASE VERBAL HEALTH CARE INFORMATION

With exceptions the law has created, you have the right to decide what verbal information Dr. Bhat can release. Please take a moment to read this form carefully to properly choose the option which best suits your needs.

I understand there are times when the law allows Dr. Bhat to release information regardless of whether or not I give my consent. For example, Dr. Bhat may release information to doctors, hospitals, nurses, and others who provide me with health care or prospective health care providers; to government agencies as authorized by law; to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document form.

STANDARD DISCLOSURE - I authorize Dr. Bhat and medical staff members to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse.

__Spouse_____ **__Parent_____**

__Children_____ **__Other_____**

_____ _____

__No Information - I do not authorize release of any information regarding my treatment. I choose to be a "No Information" patient and I realize that telephone calls will be refused on my behalf (Dr. Bhat's office will not be able to acknowledge or deny my absence or presence).

_____ _____ _____
Signature of Patient or *Legally Authorized Representative Relationship Date

_____ _____
Witness Date

*For purposes of this form, "Legally Authorized Representatives" include: 1) legal guardian, 2) agents authorized in a Medical Power of Attorney, 3) Attorney or guardian ad litem appointed by the court, 4) attorney retained by the patient or patient's legally authorized representative, 5) parent or legal guardian of a minor, 6) a personal representative or statutory beneficiary if the patient is deceased, that is spouse, adult children, and parents of the deceased patient.

I authorize Dr. Kris Bhat to release medical records to insurance for payment and for services and to the referring or primary care physician or other health care providers. I authorize and assign insurance benefits to Kris Bhat, MD for services rendered. I am responsible for deductibles, coinsurances, copays, and obtaining referrals when necessary.

Signature_____Date_____ Minor's Name_____