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CONSENT TO READ AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is the office's policy to require your reading and signing this consent prior to the provision or treatment of any other medical services. If you have any questions please call, the contact number on the bottom of the first page.

I,_____, do hereby consent to the use and disclosure of my individually identifiable health information by Dr. Sastry for the purpose of providing treatment to me, receiving payment for responsible parties for health care service rendered by Provider, and/or engaging in health care operations such as office management, credentialing case management, and quality management.

I understand that the "Notice of Privacy Practice" form, describes in more detail the types of uses of disclosures of Protected Health Information involved in payment or health care operations, and that I received a copy of this notice prior to signing this consent.

I understand that if I sign this consent, I still have the right to request a restriction on Provider's use or disclosure of any and/or all personal health information to any and/or all locations, entities, or individuals. I further understand that the provider is not obligated to agree to my request. However, if the provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing at any time. Except to the extent that the provider already relied on this consent and that any revocation will become effective on the date it has been received by the provider and will continue to use and disclose my health information after the date stated below.

_____ _____

Patients signature (or authorized individual) Date