Authorization for Release of Medical Records

Patient Name: ____

Date of Birth: ________________________________ Phone: __________________________

Address: ____

City: _____________________________ State: _____________________ Zip:___________

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: ____

Address: ____

City: ______________________________ State: _____________________ Zip:__________

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   _____ Complete health records　　_____ Lab results/X-ray reports/CT scan

   _____ Physical exam　　_____ Echocardiogram

   _____ Pulmonary Function Test/ABG　　_____ Sleep Studies

   _____ Other (please specify: ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. *This information may be disclosed to and used by the following individual or organization.*

Name: PRANA HEALTH, PLLC

Address: 2911 Breezewood Avenue # 100
Fayetteville, NC 28303
(P) 910-824-7619 (F) 910-824-7754

For the purpose of: Evaluation and Treatment

Rahul K. Kakkar, MD, FCCP, FAASM
Certified in Internal Medicine, Pulmonary Disease, Critical Care and Sleep Medicine by American Board of Internal Medicine and by National Board of Physicians and Surgeons
Certified by American Board of Sleep Medicine, and American Board of Obesity Medicine
2911 Breezewood Avenue, # 100, Fayetteville, NC 28303; 1139 Carthage St. # 105, Sanford, NC 27330
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www.prana.healthcare

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:____ .

7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: ____ ,

______________________________	______________________________
Signature of patient or legal representative	Signature of witness
Date:_________________________	Date: _________________________

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