Aparna Iyer, M.D.

Board Certified Psychiatrist

AUTHORIZATION RELEASE FOR THE EXCHANGE OF CONFIDENTIAL AND PRIVILEGED INFORMATION

I hereby authorize Dr. Aparna Iyer, located at 6842 Lebanon Road Suite 103 in Frisco, TX 75034, to release and obtain the individual's protected health information to and from the following:

_____

WHO CAN RECEVE AND USE THE HEALTH INFORMATION

_____

PHONE

_____

FAX

_____

STREET ADDRESS APARTMENT/SUITE NUMBER

_____

CITY STATE ZIP CODE

I understand that this information will be used solely for the purpose of my treatment.

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

I understand that even if this consent expires or is revoked, Dr. Iyer may be required to disclose information in the following situations:

1. If the patient is at imminent risk of harm to self.
2. If the patient is at imminent risk of harm to others.
3. If Dr. Iyer is subpoenaed to testify in court.
4. If Dr. Iyer suspects abuse to or neglect of a child, elderly person, or person with a disability.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

APARNA IYER, MD
6842 Lebanon Road, Suite 103, Frisco, TX 75034 | Office (972) 380-1842 | AparnaIyerMD@gmail.com
Texas Medical License Q6635 | *NPI* 1881844165

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WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only "All health information."

___ All health information ____Physician's Orders ____Progress Notes

____Pathology Reports ____History/Physical Exam ____Patient Allergies

____Discharge Summary ____Billing Information ____Past/Present Medications

____Operation Reports ____Diagnostic Test Reports ____Lab Results

____Consultation Reports ____EKG/Cardiology Reports ____Radiology Reports&Images

____Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)

_____Drug, Alcohol, or Substance Abuse Records

_____Genetic Information (including Genetic Test Results) _____ HIV/AIDS Test Results/Treatment

REASON FOR DISCLOSURE (Choose only one option below)

____Treatment/Continuing Medical Care ____Personal Use ____Billing or Claims

____Insurance ____Legal Purposes ____Disability Determination

____School ____Employment ____Other:_____

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I affirm that I have had the opportunity to examine this authorization and that I understand the information contained and the rights and privileges I am now waiving. My signature represents my permission for Dr. Iyer to release and obtain information relevant to my treatment.

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PATIENT NAME PATIENT DATE OF BIRTH

SIGNATURE OF PATIENT OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE

TODAY'S DATE

PRINTED NAME OF LEGALLY AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

IF REPRESENTATIVE, SPECIFY RELATIONSHIP TO THE INDIVIDUAL:

____PARENT OF MINOR ____ GUARDIAN ____OTHER:_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE OF MINOR INDIVIDUAL DATE

Covered entities, as that term is de ned by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health

information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

• Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501). • Drug, alcohol, or substance abuse records.

• Records or tests relating to HIV/AIDS.

• Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.