Krishna Sunkureddi, MD

Authorization for Release of Medical Records

I authorize the following protected health information to be released from the medical record of:

LAST NAME (PLEASE PRINT) _____ FIRST NAME (PLEASE PRINT) _____ DATE OF BIRTH _____

ADDRESS _____ EMAIL _____ TODAY'S DATE _____

PHONE NUMBER _____

Release Records
- ☐ **From**
- ☐ **To**

Krishna Sunkureddi, MD
1406 Stonehollow Dr. Ste. 600
Kingwood, Texas 77339
Phone: 281-358-0502
Fax: 281-358-0085

Release Records
- ☐ **To**
- ☐ **From**

NAME/ORGANIZATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

☐ **Please call when my records are ready for pick-up** ☐ **Please fax my records** ☐ **Please mail my records**

➡ I understand that if my record is over 25 pages it may be mailed instead of faxed.

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED	DATE/ DATES OF SERVICE	REASON FOR RELEASE
☐ Complete Record	_____	☐ Continuity of Care
☐ Progress notes only	_____	☐ Coordiation of Care
☐ Lab Results only	_____	☐ Personal
☐ Other (specify)	_____	☐ Other:
	_____	

➡ NOTE: If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

I understand that this authorization is valid for twelve months unless I notify otherwise. I may revoke this authorization in writing at any time except to the extent that my record has already relied on this authorization. I may revoke it by mailing or faxing a written notice to the office at the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. The information will be provided to me within 10 business days of my request.

⇨ NOTE: If mailing or faxing this form, please include a copy of your photo ID.

There is a fee of $25 for the first 25 pages and $0.50 for each page after that.

SIGNATURE OF PATIENT (OR IF LEGAL REPRESENTATIVE-STATE AUTHORITY TO ACT) _____ DATE _____

STAFF SIGNATURE / DEPARTMENT _____ DATE _____

STAFF ONLY

Date Released: _____ Released by: _____

Notes: _____