HIPAA Disclosure Form

Patient Name: _____ **Date of Birth:** _____

Section I: Release of Medical Information

I ***DO NOT*** authorize the release of any medical **information.(Continue to Section** II)

I, the Patient/Guardian, hereby authorize the office of Krishna V. R. Sunkureddi, M.D., P.A. to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, or fax to the following people :

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor/ Facility: _____ Phone: _____

Doctor/ Facility: _____ Phone: _____

Section II: Practice to Patient Telecommunications

When contacting Patient/Guardian, may we identify ourselves over the phone? ☐ **Yes** ☐ **No**

If unable to reach you directly, ***our office is authorized to:***

☐ *leave a **detailed** voice **mail.***

☐ *leave **a brief message asking for a return call.***

Signature: _____ Date: _____

Patient Name:_____ **DOB:.**_____

PHARMACY INFORMATION

Our office is currently transitioning to E-Scribe (meaning that we will have the ability to electronically send your prescriptions to your pharmacy, on file). We ask that you assist in this process by providing us with the following information.

- Retail Pharmacy Information
  Pharmacy: _____
  Pharmacy Phone: _____
  Pharmacy Address: _____

- Mail Order Pharmacy Information
  Pharmacy:_____
  Pharmacy Phone:_____
- Pharmacy Fax:_____

If your insurance requires a 90 day script it is your responsibility to let your clinician know ***DURING* your visit.

Note: Per treatment plan, it is your responsibility to schedule your follow up appointments ***BEFORE*** you run out of medication. We do not respond to pharmacy refill requests. If you choose not to schedule your follow up appointment at the end of each visit we will not authorize refills until you are seen by your clinician.

_____ _____

signature date

CONTROLLED SUBSTANCE PRESCRIPTIONS

Dear Patient,

You are taking a medication that is controlled by the United States Drug Enforcement Agency. There are several requirements that we must follow in order to issue this prescription. Foremost you **MUST** take your medication according to the clinicians recommendations. Any deviation can result in the prescription being denied and never used in your treatment again.

1. We cannot call these prescriptions into a pharmacy **EVER.**
2. If you find yourself in a circumstance that will require an early and/or late refill you must notify this office to explain before authorization will be given to the pharmacy to fulfill your order.
3. If at any point your written prescription becomes damaged you must return the damaged prescription to this office or submit a police/fire report to substantiate the damage.
4. We do not replace **EXPIRED** prescriptions. We do not replace lost prescriptions **EVER**
5. If your prescription is stolen you must provide us with the police report with a case number.
6. If your clinician changes your controlled substance prescription you will need to bring any of the leftover medication to this office for disposal.
7. If you share your medication with anyone, you are in violation of the law. There will not be any holdover prescriptions written and you are in jeopardy of being discharged from the practice.
8. If you miss your follow up appointment you will not get any refills. It **is your responsibility to make your appointments and keep them. Not receiving a reminder call is not an excuse**
9. If this practice becomes aware that you are receiving controlled substance prescriptions from another provider and you did not report such to us then you are in jeopardy of being discharged from this practice.

We take the federal regulations seriously and will not in any way knowingly violate those regulations please do not ask us.

IF WE BECOME AWARE THAT YOU HAVE ALTERED A PRESCRIPTION YOU WILL BE IMMEDIATELY DISCHARGED AND YOUR FILE WILL BE SENT TO THE TEXAS DEPARTMENT OF PUBLIC SAFETY FOR POSSIBLE CRIMINAL PROCEEDINGS.

CONTROLLED SUBSTANCE PRESCRIPTIONS ACKNOWLEDGEMENT

I, _____, affirm that I have received and understand the controlled substance policy for the office of Dr. Krishna Sunkureddi. I agree that I will not ask or expect the clinicians or staff of the practice to vary from the stated policy