

**AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

**Authorization for Use/Disclosure of Information:** I voluntarily authorize and direct the health care provider, Dr. T.M. Kalra and Associates, to disclose my health information to the recipient that I have identified below.

**Recipient and Address for Delivery of Records**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose:** I understand that the specific purpose of this Authorization is

\_\_\_\_\_

**Information to be disclosed:** This authorization permits the above named health care provider to disclose the following medical records:

\_\_\_ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

\_\_\_ All of my health information described above except for the following:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

