RAJ SHIWACH, MD PA

941 YORK DRIVE SUITE 205
DESOTO, TEXAS 75115
P: (972) 283-6286 F: (972) 331-8748

VOICEMAIL AUTHORIZATION

Name of Patient:_____ Date of Birth: _____

I hereby authorize providers and personnel of Raj Shiwach, MD PA to leave messages for me on the telephone numbers I provide and to identify themselves as being affiliated with the office.

_____ _____
Signature of Patient or Patient Representative **Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

I hereby authorize medical providers and personnel of Raj Shiwach, MD PA to discuss my protected health information with:

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____ Information regarding the patient's diagnosis and treatment for HIV/AIDS

____ Psychotherapy notes from a psychiatry provider or therapist/counselor

____ Treatment for alcohol or drug abuse reports

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that such revocation is not effective to the extent that the office has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Patient Representative **Date**

_____ _____
Printed Name of Patient Representative **Description of Patient Representative's Authority**