SUNIL K KOTTUR MD

Board Certified - Psychiatry & Child/Adolescent Psychiatry

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Consent for release of Information

Pursuant to the Health Information Portability and Accountability Act (HIPAA), Authorization is required to receive or disclose Medical Records aka Protected Health Information (PHI). [Exceptions to HIPAA: PHI can be released without consent in case of a) Court/Judge Order b) Abuse/Neglect c) Circumstances deemed to be a threat to the safety of the patient or others, etc]

I hereby authorize **Sunil K. Kottur, MD** to receive or disclose Protected Health

Information of Patient: ____

DOB: ____

by method of Telephone, Fax, Mail, Email, EMR etc. (This consent can be revoked at any time in writing).

From/To:

Doctor/Clinic____

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__________________________ __________________________

Tel: Fax:

______________________________ ______________________________

Signature Printed Name and Date

(If patient a minor, indicate relationship)