Shashi S Bellur M.D. FACC, FSCAI, PA
600 River Pointe Dr, Suite 101
Conroe, Texas 77304-2867
936-756-8484, Fax 936-756-8465

Authorization for Release of Confidential Medical Information

I hereby authorize use or disclosure of my protected Medical Information about me as described below. Dr Bellur may ***receive / send*** *my* protected Medical Information.

(Please Print)

Patient Name: _____

Date of Birth: _____ **SS#:** _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would than no longer be protected by federal regulations.

Request Records ***From / To***

Name of Physician: _____

Address: _____

_____

Phone #: _____ Fax #: _____

I understand that this information may include information relating to laboratory test of HIV infection or Aids related conditions, treatment of drug or alcohol abuse, mental behavior health or psychiatric care (excluding psychotherapy notes. I may revoke or withdraw this authorization by notifying the office of Shashi S Bellur MD in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be revered, and my revocation will not affect those actions, I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me whether or not I sign this authorization.

_____	_____
Signature of Patient	**Signature of Patient's Representative**
_____	_____
Patient's printed name	**Representative's printed name**
_____	_____
Date	**Date**

This authorization will expired 365 days from the date signed unless otherwise specified.