SITARA KOMMAREDDI, M.D., PLLC
6567 East Carondelet Drive, Suite 435
Tucson, AZ 85710
Phone: (520) 512-5757 Fax: (520) 882-3211

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient's Full Name _____ Maiden Name _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ (___)___ Telephone # SS # ___-___-___

Purpose for Release _____

I hereby authorize [ ] Obtain from [ ] Release to

Facility _____

Address _____

(___)___ Telephone Number (___)___ Fax Number

[ ] I hereby consent to the release of **ALL** my medical records **INCLUDING** information protected by state/federal law related to alcohol and drug abuse, psychological illness, sexually transmitted disease and HIV testing unless otherwise indicated below.

[ ] I hereby consent to the release of **ALL** my medical records **EXCEPT** information protected by state/federal law as listed above.

[ ] Specific records only as checked below:

_____OB/GYN records _____X-ray reports

_____Surgical reports _____Pathology reports

_____All lab reports _____Consultation reports

_____Specific lab reports _____Correspondence/Notes

_____Other, Please specify_____

I further release the physician and employees of Sitara Kommareddi, M.D., PLLC from any liability arising from the release of this information to the above-stated person or facility, provided the said release is performed in accordance with the applicable law.

Signature of Patient/Guardian (legal representative) _____ Relationship to patient if signed by Guardian

Date signed _____ Witness _____