from the desk of

NINA KUMAR, DDS

x-ray release

address
405 Lexington Ave
Tower Suites 6900
New York, NY 10174

tel 212-867-2967
fax 212-697-0677

Date: ____ / _____ /_____

Pt Name: _____

DOB: ____ / _____ /_____

I request and authorize the Dr. Nina Kumar & staff to release health care information of the patient named above to:

_____

_____

_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive this information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of Patient/Patient's Authorized Representative

Date Signed: _____ / _____ /_____