Sudar Tanga, MD

Board Certified in Pain Management and Anesthesiology

Shreveport-Bossier Pain Clinic
7923 Line Ave. – Shreveport, LA 71106
Phone: (318) 752-7960 Fax: (318) 752-7880

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____
PRINTED NAME OF PATIENT SOCIAL SECURITY NUMBER

_____ _____
DATE OF BIRTH ALTERNATE NAMES (IF APPLICABLE)

SEND INFORMATION TO: Shreveport-Bossier Pain Clinic / Dr. Sudar Tanga, MD
7923 Line Avenue, Shreveport, LA 71106
Phone: 318-752-7960 Fax: 318-752-7880

INFORMATION TO BE RELEASED FROM: _____

_____

_____

Phone: _____ Fax: _____

PURPOSE OF DISCLOSURE: ☐ Transfer of care ☐ Self ☐ Specialist ☐ Other: _____

INFORMATION TO BE DISCLOSED:

- ☐ Consultation Report
- ☐ Office Notes from Last _____ Visits
- ☐ Radiology Reports – MRI / XRay
- ☐ Operation Reports
- ☐ Other _____
- ☐ Dates of Service _____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dates within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for the instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996. I acknowledge that I have received a copy of the Notice of Privacy Practices. _____
INITIALS

_____ X _____ _____
DATE SIGNATURE RELATIONSHIP TO PATIENT

DISCLOSURE REQUIRING SPECIAL CONSENT:

- ☐ Drug, Alcohol Abuse / Treatment
- ☐ Mental Health / Psychiatric Disorders

_____ X _____ _____
DATE SIGNATURE RELATIONSHIP TO PATIENT