KATY
Pain and Spine

☐ **Karan Madan, MD.** ☐ **Nimish Davé, MD.**
☐ **Dawnna Walton, MD.**

AUTHORIZATION TO DISCUSS OR DISCLOSE HEALTH INFORMATION

I authorize *(circle one)* **Dr. Karan Madan / Dr. Nimish Davé / Dr. Dawnna Walton** to discuss and/or disclose my health information with the following person/persons below:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service / psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: _____

Patient's Name: _____

SSN# _____ DOB: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

This form is valid for one year from the patient signature date.