

**Sweetwater Pulmonary Associates**  
**Dr. Sandip Desai M.D. and Dr. Manpreet Mangat M.D.**  
Board Certified in  
Pulmonary Disease and Critical Care

**CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

I, \_\_\_\_\_ hereby authorize Dr. Sandip Desai and/or Dr. Manpreet Mangat hereafter called this office, to use and/ or disclose my health information which specifically identifies me or which can reasonably be used to identifies me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Sandip Desai or Dr. Manpreet Mangat can refuse to treat me.

I have received a copy of the Notice of Privacy Practices ("Notice"), which more fully describes the uses, and disclosure that can be made of my individually identifiable health for treatment, payment and health care operations.

I understand that I may revoke this consent at anytime by notifying this office Privacy Officer, in writing, but if I revoke my consent, such as revocation will not affect any actions that this office took before receiving my revocation.

I understand that I have the right to request that this office restricts how my individually identifiable health information is used and/ or disclosed to carry out treatment, payment and health operations. I understand that does not have to agree to such restrictions, but that once restrictions agree to, this office must adhere to such restrictions.

\_\_\_\_\_  
Signature of Patient or Legal  
Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guarding

Relationship to Patient: \_\_\_\_\_

