Raj Saralaya, M.D., P.A.
Shilpa Saralaya, M.D., P.A.
1215 S. Coulter, Ste. 403
Amarillo, TX 79106
806-677-2002

Patient Name: _____ (Please Print)

I hereby authorize the Doctor and/or the nurse to leave lab and/or radiology results and other messages pertaining to my healthcare on my message machine or voice mail at this number _____.

Also the message may be left with _____.

Initial: _____
Date: _____

I agree to make known any change in my insurance coverage benefits at the time of my visit. I will be responsible for making full payments or monthly payments on any balance that results from benefits not paid by my insurance company such as benefits that are applied to my deductible or co-insurance, or any balance that the insurance company deems not is my responsibility due to contracted benefits.

Initial: _____
Date: _____

I, _____ authorize the release of my medical records to physicians I am referred to/and or to medical health facilities in which I have received or will receive, medical services.

Initial: _____
Date: _____

I, _____ authorize

_____

(Full Name) (Tele) (Relationship)

to receive any of my personal medical information from Dr. Saralaya's office. I understand this authorization is in effect until I write a letter revoking this authorization.

Initial: _____
Date: _____