AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient:	Date of Birth
Name of Patient/Previous Names	Birth Date/Medical Record Number
Street Address	Social Security No.:
City, State, Zip	I am the: ☐ Patient ☐ Parent ☐ Guardian ☐ Designee
AUTHORIZES (RELEASE OF MEDICAL INFORMATION FROM):	**RELEASE OF PROTECTED MEDICAL INFORMATION TO:**
Name of Health Care Provider/Plan/Other:	Name of Health Care Provider/Plan/Other:
Street Address	Street Address
City, State, Zip	City, State, Zip

INFORMATION TO BE RELEASED:

☐ Medical History	☐ Laboratory Reports
☐ Treatment or Tests	☐ Entire Record
☐ Consultations	☐ Immunizations
☐ Other (Specify):	☐ X-Rays or X-Ray Report
☐ Surgical Reports	☐ Prescriptions

For the following dates: From _____ to _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ Further Medical Care	☐ Legal Investigation or Action
☐ Insurance Eligibility/Benefits/Claims	☐ Changing Physicians
☐ Workers Compensation	☐ Personal
	☐ Other (Specify): _____

HIPPA PRIVACY RULE: CONSENT, INFORMATION DISCLOSURE,AND AUTHORIZATION

Right To Inspect or Copy The Health Information To Be Used Or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Parham Gharagozlou, MD (925 8496634).

Right To Receive Copy Of This Authorization - I understand if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form. Right To Refuse To Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition, treatment payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right To Withdraw This Authorization - I understand written notification necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Parham Gharagozlou, MD, Privacy Officer. I am aware my withdrawal will not be effective as to uses and/or disclosures of my health information that the Person(s) and/or organization(s) listed above have already made in reference to this authorization.

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPPA) and will be used only with patient consent. I hereby authorize _____, to furnish information to other providers or healthcare or treatment facilities.

I acknowledge that the information to be released may include material that is protected by federal law. My initials and signature below authorize release of the following type of information: ☐ Drug/Alcohol Abuse ☐ Mental Health ☐ HIV/AIDS

_____	_____
Signature of Patient/Legal Representative	Signature of Witness
_____	_____
Date	Date