Parham Gharagozlou, MD INC
3108 Willow Pass Rd, Concord, CA 94519
Tel: 925 849 6634
Fax: 925 849 6635

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:
Patient Name: _____
Address: _____
_____
Phone: _____
SSN: _____Date of Birth: _____/_____/_____
I authorize the custodian of records or other person/entity,
Name of entity: _____
to disclose/release the following information* (check all applicable):

- ☐ All records including physician notes
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically)
- ☐ CPAP compliance records

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis,*
drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.
These records are for services provided on the following date(s): ---------- to ----------
Please send the records listed above to:

Parham Gharagozlou, MD
Via
☐ Mail:3108 Willow Pass Rd, Concord, CA 94519 ☐ Fax: 925 849 6635

The information may be used/disclosed at my request
This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Maryland medical records.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization.
By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date:

_____ _____
Printed name of patient representative Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*