

Rouzbeh Parsi, M.D.
President

Richard C. Wisman, M.D.
Secretary



Bahman Parsi
Chief Executive Officer

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
(RELEASE FORM MUST BE COMPLETED IN ORDER TO BE VALID)**

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ Telephone No. _____

Name of Facility or Physician Authorized to Release: _____

Address: _____ **Telephone #.** _____

Name of Facility or Person Authorized to Receive: _____

Address: _____ **Telephone #** _____

INFORMATION TO BE RELEASED (Please be as specific as possible and limit information to only that which is absolutely necessary)

Progress Notes Laboratory Reports Radiology Reports X-ray Films
 Billing Statements Others (Specify) _____

SPECIFIC DATES OF SERVICE / TREATMENT NEEDED: FROM: _____ TO: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental, psychiatric health services, treatment for alcohol and drug abuse, domestic and physical abuse.

REASONS FOR DISCLOSURE:

Continuity of Care Physician Change Insurance Eligibility/Benefits
 Legal Personal Others _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the facilities health information department. I understand that the revocation will not apply to information that has already been released in response to this Authorization. Unless otherwise revoked, this authorization will expire in **90 days**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of coverage. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (facility HIM director, privacy officer, or other office or individual's name or contact information). By signing below, I am certifying my agreement, which the statement made in this form and agreeing to the release of my protected health information as indicated by this form

Signature of Patient

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness