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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

___________________________ _____________________
(PRINT PATIENTS FULL NAME) (DATE OF BIRTH)

__________________________________ ____________________
(STREET ADDRESS) (SS#)

_________________________________ _____________________
(CITY, STATE, ZIP CODE) (MAIN PHONE #)

I, _______________________________ do hereby authorize Dr. Massoud Saberinia to release my medical records to:

Facility name: ____
Address:
____

Phone number: ___________________________

Fax number: _____________________________

I hereby authorize disclosure of the health information for the above name printed. This authorization is valid for **ONE** time from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and then no longer be protected by federal regulations. I understand that the medical provider whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

____ ___________________
Signature of individual or guardian of patient Date

****NOTE*: **There will be a charge for a personal copy or the permanent transfer of your records.**