DR. KAMRAN GOUDARZI

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION & REFUSAL TO AUTHORIZE OR CONSENT

I ______________________ **DOB** ________ **Authorize** ____________________

(please print) patient name GOUDARZI

TO DISCLOSE THE FOLLOWING INFORMATION FROM MY RECORDS.

2. **THIS INFORMATION IS TO BE DISCLOSED TO: (INITIAL EACH BOX)**

For the purpose of: Treatment, Health Care Operations, Billing and Payment or Other (please specify) ____________________

- ❑ **Complete health record (includes: treatment, health care operations, billing and payment, etc)**
- ❑ History & physical examinations
- ❑ Consultation reports
- ❑ X-ray reports
- ❑ Billing information
- ❑ Discharge summaries
- ❑ Progress notes
- ❑ Laboratory tests
- ❑ Photographs, videotapes, digital or other images
- ❑ Operative notes
- ❑ Ultrasound reports
- ❑ Other (please specify)

3. **THIS INFORMATION IS TO BE DISCLOSED TO: (INITIAL EACH BOX)**

- ❑ Family, Guardian or Representative-Name of person (s) ________________
- ❑ Doctor (name) ____________________
- ❑ Clinic, Hospital or Surgical Center (name) ____________________
- ❑ Insurance Company
- ❑ **All the above**
- ❑ Other (please specify) ____________________

The facility, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of this information to the extent indicated and authorization herein.

I have read the contents of this NOTICE OF PRIVACY PRACTICES. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment and health care operations.

SIGN: ______________________ ______________________

patient (or legal guardianre) RELATIONSHIP TO PATIENT

______________________ ______________________

signature of witness DATE

NOTICE TO PATIENT:

*By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of treatment, various activities associated with payment and health care operations. Our NOTICE OF PRIVACY PRACTICES provides more detail on our treatment, payment activities and health care operations. If there is not a copy of the NOTICE accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclose and describe certain rights you have regarding your health care.

*As stated in our NOTICE OF PRIVACY PRACTICES, we reserve the right to change our privacy practices. If we should do so, we will issue a revised NOTICE. Since revisions may apply to your health care information, you have the right to receive a copy by contacting our office.

*I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

This authorization will expire only when you notify us in writing or in person.

REFUSAL TO CONSENT: NOT TO AUTHORIZE/CONSENT TO RELEASE RECORDS TO ANYONE

BY SIGNING BELOW YOU AGREE THAT IT HAS BEEN EXPLAINED AND YOU UNDERSTAND THAT NO RECORDS WILL BE SENT TO ANY WITHOUT YOU RETURNING TO THIS OFFICE TO COMPLETE A NEW RELEASE FORM.

I ____________________ **(CHART#** ________ **) DO NOT WANT MY RECORDS SENT TO ANYONE:**

SIGNATURE ______________________________ **DATE:** ________________

YOU ARE ENTITLED TO A COPY OF THIS FORM.

Revised 05/4/2007