## Authorization to disclose protected health information

Release information from:	Release information to:
	Zakir Ali, M.D. Bear Creek Medical Plaza 1801 Hwy 99 N Ashland, OR 97520 Ph: 541-482-5515 / Fax: 541-482-2433

History and Physical.	Xray/MRI/CT reports
Followup Chart/Clinic notes	Radiology Imaging Films
Consultation reports	Cardiac Echo
Neuropsychological test report	EEG
Emergency department reports	EMG
Hospital admission note	Tests
Inpatient notes	Pathology reports
Discharge summary	Lab reports

Others \_\_\_\_

## **IDENTIFYING INFORMATION AT THE TIME OF SERVICE**

Patient's Full Name Patient's

Social Security Number/Medical Record Number

Films

Address

Patient's Date of Birth

City/State/Zip

Patient's Phone Number

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in one year from the date signed below unless otherwise specified:

I understand that I may be charged for copies of this information if records have been requested for personal use. I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

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