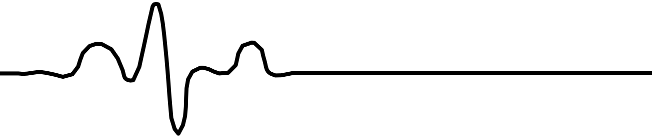
Dr. Mani Khoshnejad, M.D.



Permission to Release Personal Health Information

Patient Name:____Today's Date____/____/_____

Date of Birth:_____/_____/_____

Due to HIPPA requirements we are not allowed to release any personal medical information without that patients' consent. If the patient wishes to allow a family member (i.e. spouse, child, parents, etc.) to have access to their medical or billing information, the patient must complete and sign this form prior to any information being requested or released. Signing this form will only give access to the person(s) listed below and should be updated regularly to protect the patients' information.

I authorize the release my health and billing information to the following person(s):

Name:____ Relation to Patient:________________________

Name:____ Relation to Patient:________________________

Name:____ Relation to Patient:________________________

Name:____ Relation to Patient:________________________

By signing this form, I authorize the release of my confidential health information, including medical records, summary, narrative of my protected health information, and/or any billing information to the person(s) listed above. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect and/or copy the health information to be disclosed. I understand that any information that is disclosed to any person(s) above is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. I understand that MANI K MD PA is not to be held liable for any redisclosure of health information conducted by any of the above person(s), regardless of status of consent to release. I understand that, in order to revoke this consent, I must do so in writing with my signature then submit the original document to MANI K MD PA either by standard mail or in person but that I may keep a copy for my records.

____ _____/_____/_____

Patient Signature — Date

____ _____/_____/_____

Legal Guardian Signature (If applicable) — Date