Dr. Mani Khoshnejad, M.D.

Medical Release Form

Patient Name: _____ Today's Date____/____/_____

Date of Birth: ____/____/_____

Social Security #: _____-_____-_____

Legal Guardian Name: _____

Release my health information **TO** the following person(s) or entity:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) -_____-_____ Fax: (_____) -_____-_____

Release my health information **FROM** the following person(s) or entity:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) -_____-_____ Fax: (_____) -_____-_____

The reason(s) for this release are as follows (check all that apply):

( ) Continue Patient Care ( ) Attorney/Legal ( ) Insurance ( ) X-Rays Only ( ) Labs Only ( ) Other_____

By signing this form, I authorize the release of my confidential health information, copy of my medical records, summary, and/or narrative of my protected health information to the person(s) or entity listed below. I understand that this information is to be provided within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.

_____ ____/____/_____

Patient Signature Date

_____ ____/____/_____

Legal Guardian Signature (If applicable) Date