Elite Medical Clinic
Family Medicine + Urgent Care

2214 South Hoover Street
Los Angeles, California 90007
(213)622-3100
(213)622-3132 Fax
hkashanimd@gmail.com

HIPAA Right of Access Form for Family Member / Friend

Many of our patients allow family members such as their parent(s), grandparent(s), guardians and/or others to call and discuss medical information, request prescriptions, vaccine information, medical records, and results of test, pickup forms etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's explicit consent. If you wish to have your medical information released to others, you must sign this form. Signing this form will only give consent to release said information to the individual(s) indicated below. You have the right to remove this authorization at any time by so requesting in writing.

Patient Name: _____ **Date of Birth**: _____-_____-_____

Social Security Number: _____-_____-_____ **Driver's License #**: _____

I, _____ authorize representatives of Elite Medical Clinic and Houman M. Kashani, MD to share and/or release my **COMPLETE** health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all my conditions—this includes mental health records, communicable diseases including HIV and AIDS, and alcohol or drug abuse treatment, if any) to:

Name: _____ Relationship:_____
Tel: _____ E-mail: _____

Name: _____ Relationship:_____
Tel: _____ E-mail: _____

Patient Signature X_____ **Date:** _____