Afrouz Gerayli, MD, INC.

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RECORDS AND INFORMATION RELEASE FORM

As required by the *Health Insurance Portability and Accountability Act* of 1996 ***(HIPPA),*** it necessary to obtain written consent before disclosure/release of medical records/information to any persons or facility. If you feel that it might be necessary to release records/information in any of the situations listed below, please **INITIAL** the applicable box, list the person(s) name that may receive the records/information, sign, and date this form.

☐ Medical Test Requisition (i.e. labs, x-ray) forms and/or written prescriptions completed on my behalf

☐ my medical test results written or verbal

☐ to discuss my medical history, diagnosis, and treatment.

☐ To discuss billing/payment information concerning my account.

☐ It is necessary on occasion to release medical records/information to another medical specialist such as a Cardiologist, Urologist, Oncologist, insurance, etc. that you may be consulting with and who have requested such information to help with your medical care. Unless you prefer to take these records yourself, we must obtain your signature permitting us to release any/all pertinent information to another medical specialist or facility.

I, _____ (print name) do hereby give Afrouz Gerayli, M.D., INC or an agent of Afrouz Gerayli, MD. INC. my permission to release my medical records/information as listed above to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT SIGNATURE: _____**DATE:**_____

PARENT GUARDIAN SIGNATURE (IF APPLICABLE): _____ DATE: _____