Elite Medical Clinic
Authorization to Use and Disclose Protected Health Information

Patient Name:_____ Date of Birth_____

Current Address:_____ Phone _____

This authorization is to release the protected health information to:

Dr. Houman Kashani
2214 South Hoover Street
Los Angeles, CA 90007
Tel: (213) 622-3100 Fax (213) 622-3132
Secure Email: info@elitemedicalclinic.net

IF RECORDS ARE OVER 25 PAGES, PLEASE EMAIL OR MAIL RECORDS—DO NOT FAX!

This authorization is to release the protected health information from:

Name:_____ Phone Number_____ Fax Number_____

Address:_____City:_____ State_____ Zip_____

The purpose of this disclosure is:_____
Dates of service requested:_____

Release the following information:

___Discharge Summary	**___Pathology report(s)**	**___Itemized Billing Statement**
___History &Physical	**___Radiology report(s)**	**___Psychiatric Admitting Evaluation**
___Consultation(s)	**___Lab report(s)**	**___Psychiatric Discharge Summary**
___Operative Report(s)	**___Cardiology report(s)**	**___Psychiatric Testing**
___Progress Notes	**___Treatment plan(s)**	**___Other records as specified:_____**
___Emergency record(s)	**___Alcohol/Drug Treatment***	**_____**

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that the Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal or state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to "this facility" to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR 164.524.

To be used if facility requests this authorization:

I understand that:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility's" treatment of me.
- I may make a request in writing at any time to this facility to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR 164.524.

*Alcohol/Drug treatment records are protected by Federal Rule 45 CFR, part 2. Both a minor's and a parent/guardian's signature must be obtained prior to disclosing the minor's alcohol/drug treatment records.

If I have any questions about disclosure of my health information, I can contact the Health Information Management / Medical Record Department.

Patient Signature_____ Date_____