CAMRAN NEZHAT INSTITUTE

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RELEASE OF MEDICAL RECORDS AUTHORIZATION FORM

I, _____ _____, hereby request and authorize:
(Patient Name) (DOB)

____ **Camran Nezhat Institute** to *obtain* confidential healthcare information from the provider below:

(Healthcare Provider): _____

Phone: _____ Fax#: _____

____ **Camran Nezhat Institute** to *disclose* confidential healthcare information to:

(Healthcare Provider): _____

Phone: _____ Fax#: _____

Information to be disclosed (check all that apply):

- ❑ **Complete Medical Record**
- ❑ **Progress Notes**
- ❑ **Surgical Reports (Operative and Pathology Reports)**
- ❑ **Radiology Reports (MRI/CT)**
- ❑ **Laboratory Reports**
- ❑ **Other (please specify):** _____

If the entity or person receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notice to ***Camran Nezhat Institute***. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

This authorization expires 3 years after the event that relates to the purpose of this use of disclosure OR unless revoked before either event.

_____ _____

Patient Signature Date