AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: Date of Birth:

I hereby authorize the use or disclosure of the above individual's health information as described:

Information regarding health care provider or health care entity authorized to disclose this information:
Name:
Address:
Phone: Fax:

Information regarding person or entity who can receive and use this information:
Name: Sayeh Eshraghi M.D/LA Wellness Boutique
Address: 23586 Calabasas Rd, Suite 107, Calabasas, CA, 91302
Phone: 818-858-1182 Fax: 818-806-4114

Type of information to be used or disclosed (check all that apply):
__ All medical records
__ Specific information:
__ Other:

Including any of the following related confidential information (check all that apply):
__ HIV/AIDS
__ Mental health
__ Substance abuse
__ Reportable STDs

Dates of service requested:
__ All records
__ Past 12 months
__ Specific time period from:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records custodian. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify, this authorization will expire in 12 months.

I understand that treatment and/or payment is not conditioned upon signing this form.

Signature:

Printed Name: Date: