HAMID T. ZADEH, M.D.

2435 Marshall Road Imperial, CA 92251 P: (760) 550-6327 F: (760) 550-6331

RELEASE OF MEDICAL RECORDS

AUTHORIZATION: I authorize the release of information pertaining to medical history, mental health, physical condition, services rendered or treatment as described below for;

NAME OF PATIENT: _____ DATE OF BIRTH _____

SOCIAL SECURITY #: _____ TELEPHONE # _____

RECORD HOLDER: _____

_____
Street Address   City   State   Zip

RECORDS MAY BE RELEASED TO: _____

_____
Street Address   City   State   Zip

_____
Phone #   Fax#

DATE(S) OF SERVICE: _____
            From   To

LOCATION OF TREATMENT: ☐ Inpatient   ☐ Emergency   ☐ Outpatient

TYPE OF INFORMATION: This authorization is limited to the following medical record type of information:

☐ Discharge Summary   ☐ Progress Notes
☐ History/Physical Exam   ☐ Laboratory Tests
☐ Consultation Reports   ☐ X-ray Reports
☐ Operative/Procedure Reports   ☐ Photographs/Digital or other imaging
☐ Emergency Department Reports   ☐ Other (please specify):_____

SPECIAL CATEGORIES OF INFORMATION: You must specifically authorize the disclosure of the following types of information, check all that apply:
☐ HIV (human immunodeficiency virus) test results   ☐ Psychiatric Records
☐ Alcohol and/or drug abuse treatment

USE OF INFORMATION: The requestor may use the medical records and type of information authorized only for the following purposes:
☐ Continuing Care   ☐ Second Opinion   ☐ Personal   ☐ Insurance Claim   ☐ Other
(Please Specify) _____
_____

PRINTED NAME: _____ **DATE:** _____

SIGNATURE: _____

If signed by other than patient, indicate relationship:_____

Witness:_____