

Shawn A Khavari, MD PLLC  
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Edmond, OK 73034  
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**HIPAA- AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**  
**Release for Medical Records**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize two way communication of:

- \_\_\_\_\_ Entire health records
- \_\_\_\_\_ Most recent progress notes
- \_\_\_\_\_ Medication list
- \_\_\_\_\_ Billing records
- \_\_\_\_\_ Letter only  give to patient to hand to name below  to fax to number below  to mail to the name and address below
- \_\_\_\_\_ Copies of my records to be  mailed /  faxed /  personally picked up and delivered
- \_\_\_\_\_ Pathology/lab report
- \_\_\_\_\_ Other \_\_\_\_\_

**From:**

Name: Shawn A Khavari, MD PLLC  
Address: 3917 E. Covell Rd, Edmond, OK 73034  
Phone: 405- 471- 5557  
Fax: 405-471-5571

**To:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Purpose of Request: \_\_\_\_\_

I understand:

- I may revoke this Authorization at any time by providing my written revocation. My revocation will not apply to the information already retained, used, or disclosed in response to this Authorization. Unless revoked, this authorization will never expire.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, Shawn A Khavari, MD PLLC may not condition the provision of treatment or payment for my care on my signing this Authorization.
- The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.
- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal law (42CFR Part 2). Federal law prohibits anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the patient or is permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.
- The information authorized for release may include information which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

\_\_\_\_\_  
Signature of Patient, Parent, or Legally Authorized Representative.

\_\_\_\_\_  
Relationship to Patient.

\_\_\_\_\_  
Date