Shawn A Khavari, MD PLLC
609 S. Kelly Avenue Suite L2
Edmond, OK 73003
Phone 405.471.5557
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HIPAA- AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Release for Medical Records

Date:_____

Patient Name:_____ DOB:_____

Social Security Number:_____ Phone:_____

Address_____

I hereby authorize two way communication of:

_____ Entire health records
_____Pathology/lab report
_____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 ☐
_____Other_____

Copies of my records to be mailed _____ / faxed _____ / personally picked up and delivered _____

From:
Name: Shawn A Khavari, MD PLLC
Address: 609 S Kelly Avenue Suite L2, Edmond, OK 73003
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, the automatic expiration date will be twelve months from the date of signature.
- 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 in 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