Authorization to disclose protected health information

Release information from:	Release information to: **Zakir Ali, M.D.** **Bear Creek Medical Plaza** **1801 Hwy 99 N** **Ashland, OR 97520** **Ph: 541-482-5515 / Fax: 541-482-2433**

___History and Physical.
___Followup Chart/Clinic notes
___Consultation reports
___Neuropsychological test report
___Emergency department reports
___Hospital admission note
___Inpatient notes
___Discharge summary

___Xray/MRI/CT reports
___Radiology Imaging Films
___Cardiac Echo
___EEG
___EMG
___Tests
___Pathology reports
___Lab reports

Others ____

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

Patient's Full Name Patient's ______________________

Social Security Number/Medical Record Number ______________________

Address ______________________

Patient's Date of Birth ______________________

City/State/Zip ______________________

Patient's Phone Number ______________________

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.
I understand that this authorization will expire in one year from the date signed below unless otherwise specified: ______________________
I understand that I may be charged for copies of this information if records have been requested for personal use.
I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing.
I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

*Signature of Patient or Patient's Representative** ______________________ *Relationship (if not patient)* ______________________ *Date* ______________________

*If a personal representative of the patient signs the authorization, please indicate his or her authority to act.

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