MAHSA SOHRAB MD
OCULOFACIAL PLASTIC SURGEON

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's name_____ DOB_____

I request and authorize Dr. Mahsa Sohrab to release my healthcare information to:

Name_____

Mail to address_____

or Fax to _____ Attention_____

This request applies to healthcare information relating to the following treatment, condition or dates ONLY:_____

I understand the following:

1) I may revoke this authorization by providing written notice to the office.
2) The practice will not condition treatment or payment based on my signing this form.
3) I am signing this authorization freely and under no pressure to do so.
4) The information disclosed in this authorization may be subject to re-disclosure by the practice and may be no longer protected by federal law.
5) I acknowledge that I have had an opportunity to review this authorization and understand it's intent and use.

This authorization expires in 6 months from the date signed, unless otherwise specified by me.

Patient signature_____Date_____

Parent/Guardian name/signature_____

Relationship to pt._____Date_____