ANIL MOHIN MD, FACC, INC.
www.drmohin.com

## AUTHORIZATION FOR RELEASE OF INFORMATION

I:_____ with Date of Birth:_____
hereby request and authorize:
To:_____At:_____
Address:_____
Tel:_____ Fax:_____
To release medical records to:

Clínica Médica Alvarado E Instituto de Cardiología
745 South Alvarado Street
Los Angeles, CA 90057

The following information may be released:_____ entire record.
This information is being disclosed for the following purpose (s):
_____
_____

- I understand the information may include information regarding drug or alcohol abuse, mental health and/or HIV related information. I release the above from all legal responsibility or liability that may arise from the act I have authorized. I understand that once the information is released per this authorization it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- Records from other facilities: Anil Mohin MD will release only medical information documented/dictated on treatment received at this facility. If you have been treated at other facilities please contact them to make arrangements to release any information you may need. This information will expire on the following date ____/____/____ if not specifically stated then one year after date of signature. I understand that this authorization can be revoked in writing and I need to present my written revocation to the Health information Coordinator at Anil Mohin MD office. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I need not sign this form in order to ensure health care treatment or payment unless the treatment is for research or requested by a third party.
- The following applies to Substance Abuse records only: THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISION OF FEDERAL STATUTES (21 U.S.C. 1175 OR 42 U.S.C. 4582 and regulations 42 CFR. Part 2) which prohibit any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I understand that I will be given a copy of this authorization form after signing.

Signature of patient of legal representative:_____ Date:_____
If signed by legal representative, relationship to patient is:_____

For office use only:
Faxed on: _____/_____/_____ at _____ am/pm