Authorization For Use By or Disclosure of Health Information To Dr. PM Sleep & Wellness Center

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient Information Name Last, First _____ Date of Birth _____

*Release To:

I, _____(please print), hereby authorize Dr. Mashayekhi, Pegah to release information from or copies of my medical records to (fill in the section below that applies):

☐ **Release of Records for Myself**

I will pick up the records ☐ Mail to address on record ☐

Email to: _____

Fax to: _____

☐ **Release of Records for a Physician or Other Party**

Name Last, First _____

Street _____

City _____ Phone _____

State, Zip Code _____ Fax _____

☐ **Release of Records for Dr. PM Sleep and Wellness Medical Clinic**

Dr. Mashayekhi, Pegah
3230 Waring Court Suite C, Oceanside, CA, 92056

Phone: (619) 224-1866
Fax: (619) 3530419

Type of Health Information to Release: Check the Box(es) that Apply

☐	Lab Tests	☐	All Progress Studies	☐	Specific date of service
☐	HIV test results	☐	All Diagnostic Studies	☐	History and physical exam
☐	Psychiatric	☐	X-ray film (Fee applies)	☐	Pertinent Reports for transferring doctors
☐	Sleep Studies	☐	All Progress Notes	☐	All available medical records. Fee applies. (Not to be used for transferring doctors/referrals)
☐	Substance abuse	☐	Recent Progress Notes	☐	All for specific medical condition(s):

The Purpose of this Release

Continuing medical care		☐	Insurance
At my request (fee may apply)		☐	Legal Matter
Other:		☐	School
Specify limitations (if any) on the use of the information:			

Expiration of Authorization

This authorization becomes effective upon signing and expires with a written request by the patient.

Patient's Printed Name	Date of Birth	Relationship to Patient
Patient/Guardian Signature	Date	Print Name of Legal Representative