Pargol Samani MD, INC.

3927 Waring Rd, Suite, Oceanside, CA 92056 Phone: (619) 703-7220 Fax (619) 703-7221

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

Name of patient: ---------- Date of birth: ----------
Phone number: ---------- Social Security number: ----------

I hereby request and authorize ---------- to release healthcare information of the patient named above to:

Pargol Samani MD, Inc
3927 Waring Rd, Suite C, Oceanside, CA 92056
Phone: (619) 703-7220 | Fax: (619) 703-7221

The request and authorization applies to:
✓All health information pertaining to my medical history or physical condition and treatment receive, including:
✓History and Physical Reports ✓EKG ✓ Echocardiogram ✓Carotid Ultrasound ✓Aortic Ultrasound
✓Lower extremities Ultrasound ✓Renal Ultrasound ✓Stress Test ✓Procedure Report
✓Radiology Report ✓Discharge Summaries ✓Emergency Department Reports ✓Laboratory Reports
✓All healthcare information on record
✓Other: ----------

Purpose of requested use or disclosure is Patient request; OR Other: ----------

I understand and acknowledge that these records may include mental health treatment information, HIV test results and alcohol/drug treatment information. A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.1 This authorization expires 90 days after it signed.

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Pargol Samani, MD, Inc, 3231 Waring Ct, Suite P, Oceanside, CA 92056.
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE (patient/legal representative) Date: ----------

If signed by a person other than the patient, indicate relationship: ----------

Print name: (legal representative) ----------