Maryam Eskandari, M.D.

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CONSENT TO RELEASE INFORMATION

Patient's Name:_____

Guardian (if patient is a minor):_____

Patient's SSN:_____ Date of Birth:_____

I, _____, request and authorize MARYAM ESKANDARI, M.D. to release my medical & mental healthcare information to:

Name and/or Organization:_____

Phone #:_____ Fax #:_____

Address:_____

City, State and Zip Code:_____

Email:_____

... and further consent to an exchange of information between the two parties.

This authorization is for, but not limited to, the purpose of treatment and evaluation. I understand that such records may include: medical information, mental health information, drug & alcohol abuse information, and HIV/AIDs test results.

I understand that:

(1) this authorization is voluntary;
(2) the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected;
(3) I am entitled to a copy of this authorization, should I request one;
(4) this authorization will expire in 12 months from the original authorization date;
(5) I have the right to revoke this authorization at any time, by written notification only, except to the extent that the information has already been disclosed. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this.

Patient (or Guardian) Signature:_____ Date:_____