Authorization for Use or Disclosure of Protected Health Information

Patient Name: ______________________________________ DOB: ______________

FOR OFFICE USE ONLY, Please Leave Blank

I hereby authorize: ____________________________________ (Name of facility or Dr.)

____________________________________ (City, State, Zip Code)

Phone: ____________________ Fax: ____________________

to release the following information for continuance of care to:

The Cardiovascular Center

Mohamed Khan MD
Aazib Khan MD
Allyson Martin PA-C
Cathy Ludlow FNP

2425 Sonoma Street, Redding CA 96001
(530) 241-1144
(530) 241-1142 fax

Please send ONLY the following:

- **-Ekg with tracings**
- **-Most recent chart note**
- **-History and Physical**
- **-Cardiac/Vascular Procedures**
- **-Chest X-rays**
- **-Discharge Summary**
- **-ER report**
- **-Most recent Labs**
- **-Studies such as echocardiogram, stress test, vascular studies, CT scans**

_____ **Please respond if no records are available for this patient**

This authorization is subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

I understand that the recipient may not lawfully further use or disclose the Protected Health Information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. If this authorization is not revoked by the patient or responsible party, it will remain valid indefinitely.

Signature: ______________________________ Relationship to patient: __________

Witness: ____________________________________ Date: ______________