Kaveh Bagheri M.D., F.A.C.P., F.C.C.P.

Diplomate American Board of Internal Medicine
Diplomate American Board of Pulmonary Diseases
Diplomate American Board of Critical Care

HIPAA AUTHORIZATION

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize my health care provider, Dr. Kaveh Bagheri to disclose the following information:

> All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

to the following authorized persons:

Name: _____

Address:_____

Telephone:_____

Name: _____

Address:_____

Telephone:_____

Name: _____

Address:_____

Telephone:_____

VALID DOCUMENT

A copy or facsimile of this original authorization shall be accepted as though it were an original document.

WAIVER AND RELEASE

I hereby release Dr. Kaveh Bagheri and his medical staff that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

Signed on the ____ day of _____, 20__.

Signature: _____

Printed Name:_____