Anita Sabeti, M.D. Pediatrician

Authorization for use or disclose of medical information

I, the undersigned, authorize the release of, or request access to the confidential information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including X-rays, and/or correspondence, including those from my other healthcare providers that the below named health provider may hold, by means of mail, fax, or other electronic methods. I understand the potential for this information to be re-disclosed by the recipient and therefore no longer protected by the federal privacy rule.

Please note that for patients older than 18 years of age we need the patient's consent.

AUTHORIZATION:

I hereby Authorize: Physician/Healthcare Facility:. . . . . .

Address: . . . . . City . . . . . .

State: . . . . . Zip. . . . . Phone: . . . . . Fax. . . . . .

To release my medical information to: Dr. Anita Sabeti

9735 Wilshire Blvd Unit 123, Beverly Hills CA, 90212 Tel: 310.248.2829 Fax: 310.248.2864

Type of records requested:

❏ Complete Medical Report ❏ Immunization Record Only ❏ Other Please specify: . . . . . .

DATES OF SERVICE REQUESTED: From : . . . /. . . . . /. . . . . To: . . . /. . . . /. . . . . .

State/Federal Laws require specific authorization to release the following types of authorization. I specifically authorize the release of:

❏ Mental Health ❏ HIV test results ❏ Alcohol/Substance Abuse

A Separate authorization is required for psychotherapy notes

Would you like to have records: ❏ Mailed ❏ Picked Up ❏ Faxed (Immunization Only)

Pateint Name . . . . . DOB . . . /. . . /. . . .

Parent/ Guardian name . . . . . Relationship . . . . . .

Signature . . . . . .Date . . . /. . . /. . . . .

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