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CONSENT TO DISCLOSE PATIENT HEALTH INFORMATION TO FAMILY AND FRIENDS INVOLVED IN PATIENT CARE

Patient Name: _____ Date Of Birth: _____ SSN: _____-_____- _____

I understand that Dr. Moattari will NOT disclose my protected health information to my family, friends or relatives except in emergency situations.

I understand that Dr. Moattari may disclose my protected health information to my family, friends or relatives that I identify who is directly involved in my case or payment of my care provider that I have an opportunity to agree or object to such disclosure.

The individual(s) named bellow is/are directly involved in my care and I would like these individual(s) to give and receive information from Dr. Moattari regarding my medical condition and treatment. Therefore, I hereby consent, agree and authorize Dr. Moattari to disclose my protected health information to the following individual(s) who is/are involved in my care or in the payment of my case:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that by consenting to the disclosure of my protected health information to the individual(s) named above, all my personal information relevant to my care and treatment may be disclosed including, but not limited to, my medical history, my medical condition, diagnostic tests, performed and their results, laboratory results, surgical procedures and other personal information given to, or discussed with, my physician.

This consent is effective immediately and shall remain in effect until I revoke it. I understand that I have the right to revoke this consent at any time by providing written notice to Dr. Moattari. I further understand that I am NOT required to sign this form in order to receive treatment, and that I am voluntarily requesting and consenting to Dr. Moattari disclose my protected information to the individual(s) named above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____