# AUTHORIZATION TO RELEASE RECORDS

TO: _____

_____

_____

I hereby authorized and request that you release to:

Dr.: _____

_____

_____

I hereby authorize the above medical doctor to release any information acquired in the course of my examinations and/or treatments from the period of _____to _____.

Please send M.R.I results of _____

Patient Name: _____ D.O.B: _____

(Full Name-Previous Name if recently changed)

Patient Signature: **X** _____

Signature of Parent or Guardian if Patient is Minor: **X** _____

Date: _____ Witness: _____

## PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means, such as sending a correspondence to the individual's office instead of the individual's home. I have read, understood and received the HIPAA Notice of Privacy Practices.

**I wish to be contacted in the following manner** (check all that apply)

____**Home Telephone #:** _____
____Okay to leave detailed information
____Leave only call back name and number

____ **Cell Phone #:** _____
____ Okay to leave detailed information
____ Leave only call back name and number

____**Work Telephone #:** _____
____Okay to leave detailed information
____Leave only call back name and number

____Written communication
____Okay to mail to my home
____Okay to mail to work/office
____Okay to fax to office

____ **Email Address:** _____

Patient signature: **X** _____ Date: _____

Print patient name: **X** _____ Date of Birth: _____

## PATIENT INFORMATION

**DATE:** _____ **PATIENT'S NAME:** _____ **BIRTH DATE**____/____/____
Fecha de Hoy Nombre de Paciente Fecha de Nacimiento

**SEX:** ____ **AGE:** _____ **SSN:** _____ **DRIVER'SLICENSE#:** _____
Sexo Edad NSS No. De Licencia

**TEL No. H:** _____ **C:** _____ **EMAIL:** _____
No. De Tel. Casa Celular Correo Electrónico

**ADDRESS:** _____ **CITY:** _____**STATE:** _____ **ZIP:** _____
Dirección Ciudad Estado Código Postal

**ETHNICITY:** _____ **LANGUAGE:** _____
Etnicidad Lenguaje

MARRIED_____ SINGLE_____ DIVORCED_____ SEPARATED_____ WIDOWED _____
Casado/a Soltero/a Divorciado/a Separado/a Viudo/a

**IN CASE OF EMERGENCY/ EN CASO DE EMERGENCIA:**

CONTACT_____TEL #_____

RELATION_____

REFERRING PHYSICIAN: _____ TEL #:_____

## ARBITRATION

It is understood that any dispute as to medical malpractice, that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court processes except as California law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it are giving up their constitutional right to have such dispute decided in court of law before a jury, and instead are accepting the use of arbitration. Such arbitration shall be accordance with the current Medical Arbitration Rules of the California Hospital Association – California Medical Association (copies available upon request). This arbitration agreement shall apply to any legal claim or civil action in connection with this outpatient service against the Center or its employees and any doctor of medicine who has agreed, at the time of your admission as evidence by written agreement in the physician's medical staff file to be bound by this provision, unless patient or undersigned initial below or unless rescinded a written notice within 30-days of signature. An agreement to arbitrate shall not be a precondition to the rendering of services under this agreement.

If patient or undersigned does not agree to arbitrate then he or she will initial here _____.

**NOTICE:**

**BY SIGNING THESE CONDITIONS OF TREATMENT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY/COURT TRIAL.**

Patient signature: **X** _____ Print patient name: **X** _____

Date: _____ Witness: _____

# AUTHORIZATION TO PAY DOCTOR

I hereby authorize the_____
(Insurance Company) to pay by check made out and mailed directly to:

_____

_____

_____

The expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above named assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

X_____

(Do not write in this space; for office use only.)
Policy No._____
Agent_____
Claims Office Address_____
_____

_____
(Street Address)

_____
(City) (State)

_____
(Date)

## AUTHORIZATION

I also authorize you to send payment to the above physician for any of my medical benefits. I understand I am responsible for any charges not paid by the insurance company. I understand that for any outstanding balance on my account, there will be a $50 monthly late charge fee as well as a $15 statement fee.

## PATIENT CONSENT FOR USE OF CREDIT CARD, DEBIT CARD, AND FINANCING DISCLOSURE OF PROTECTED HEALTH INFORMATION:

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services performed that are payable with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided.

By signing this form, I am irrevocably consenting to allow

**Kamran Hakimian, M.D. Inc.**
**Tina Hakimian MD Inc**

To use and disclose my protected health information to process an account and assist with payment.

I, _____, will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

I, _____, agree that this non credit card challenge agreement is irrevocable.

**PATIENT'S SIGNATURE X**_____ **DATE:** _____