Hilla Sadri, M.D., F.A.C.O.G.
P.O. Box 5253
San Clemente, California 92674

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____
(PRINT YOUR FULL NAME OR ANY OTHER NAME WE MAY HAVE YOU UNDER.)

Birth date: _____

Hereby authorize **Hilla Sadri, M.D.** to release information contained in my medical records to me on a CD.

Please mail CD of my Medical records to the following address:

_____

_____

_____

I understand that this authorization, UNLESS SPECIFICALLY LIMITED BY ME IN WRITING BELOW, will extend to all aspects of treatment provided by Hilla Sadri, M.D. This includes TESTING FOR ALL SEXUALLY TRANSMITTED DISEASES, INCLUDING AIDS AND HEPATITIS, as well as drug / alcohol, and/or psychiatric information.
Exclusions: Identify any specific portion of the records that you do not wish to release:_____

_____

_____

I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Hilla Sadri, MD, and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient. I understand that there is **a nominal charge of $35** for copying & processing for the first set of copies of my medical records and I have enclosed the payment.
Any **additional** requests will incur **additional prepayment** charge of **$35 before the records are processed and mailed to me.**

Signature: _____ Date: _____