

Diana K. Hashimi, M.D.

**Authorization for Use and Disclosure of Protected Health Information**

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To release information from my records to: Diana K. Hashimi, MD 4310 Old Shell Road, Mobile, AL 36608

**Phone# (251) 895-4345 Fax# (251) 341-5058**

The purpose or need for this release of information is coordination and continuation of patient primary care.

Special dates of interest: \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The specific information to be disclosed is: **Most recent TWO office notes Mammogram and/or DEXA report Lab Testing/Results X-Ray/Ultrasound Reports Operative Reports Complete Records Medication Record History & Physical Discharge Summary**  Information which may not be disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of authorization. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric, mental health and drug or alcohol use. You are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

By signing below, I hereby authorize the disclosure of information about me that is protected, under federal law, for the sole purpose and time period designated. I understand the protected health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure. Every effort will be made to protect patient privacy, as required by federal law.

**Authorization must be signed by the patient or patient’s legal representative.**

**Patient Name: Date of Birth:**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rev. 11/11/2019