GHADEER OKAYLI, M.D.

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Authorization for Release of Information or Records

Date of Birth:

Telephone:

Name:

Address:

City/State/Zip:

This is an authorization for: Dr. Ghadeer Okayli, MD Psychiatrist (please check one option)

To convey to:

OR receive from:

OR BOTH convey and receive my medical/psychiatric records.

from:

Phone:

Fax:

Please note that psychiatric records released are copied from the chart that will include substance/ alcohol use history, personal habits and other confidential personal information that were shared with your psychiatrist. If you don't wish to release this information, you need to mark release a report and specify what information needs to be recorded.

This release is for the following purposes (specify):

∗ Release a report (Specify):

∗ Release copies of ALL records:

∗ Release Specific records (Specify):

*Records

From date:

To date:

AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

Initial. _____

Date:

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.
The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Patient Name:

Signature:

Date:

OR

(Patient or person legally authorized to consent on patient's behalf)

Signature

Legal Guardian Name:

Relationship to Patient:

Legal Witness Name:

Date:

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

Initial _____