WEST PLANO MEDICAL ASSOCIATES

SAFOORA "SOPHIE" HARANDI, M.D.
BOARD-CERTIFIED INTERNAL MEDICINE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR PATIENT DESIGNATED TRANSLATOR

Patient Name_____ **Date of Birth**_____

Many of our patients allow family members such as their spouse, parents or others to request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.
I authorize West Plano Medical Associates to release my medical and/or billing information to the following person(s):

1._____

Relationship to patient:_____ **Phone Number:**_____

2._____

Relationship to patient:_____ **Phone Number:**_____

3._____

Relationship to patient:_____ **Phone Number:**_____

PATIENT INFORMATION:
I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

SIGNATURE:_____ **DATE:**_____

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