



Southern California  
Multi-Specialty Center

Dr. Babak Eghbalieh (SoCal Hepatobiliary)

Dr. Sammy Eghbalieh (SoCal Vein & Artery)

Central Office: 5805 Sepulveda Blvd # 690, Sherman Oaks CA 91411-2522

**PLEASE PRINT VERY CLEARLY**

Line items printed in bold on this page are required fields, if they apply. Thank you for your assistance.

**■ Patient Information**

Name (Last, First, Middle) \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Email address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Widowed  Separated **Sex:**  M  F  
 Race:  Black / African American  White / Caucasian  Hawaiian / Pacific Islander  American Indian  Asian  Unknown  Other  
 Ethnicity:  Hispanic  Non-Hispanic  Prefer not to specify  
 Preferred Language:  English  Spanish  Hmong  Lao  Punjabi  Sign Language  Vietnamese  Other: \_\_\_\_\_

**■ Person Financially Responsible for Account** (if same as patient, write "same" on Name line.)

Name (Last, First, Middle) \_\_\_\_\_ Relationship \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_

**■ Primary Insurance**

Policyholder's Name (Last, First, Middle) \_\_\_\_\_ Relationship \_\_\_\_\_  
 Policyholder's Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex:  M  F  
 Employer's Name (if insurance is through work) \_\_\_\_\_

**■ Secondary Insurance**

Name (Last, First, Middle) \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex:  M  F  
 Employer's Name (if insurance is through work) \_\_\_\_\_

**■ Assignment and Release**

I hereby authorize payment directly to Southern California Multi-Specialty Center (and/or its subsidiaries, including Southern California Hepatobiliary Pancreatic and Robotic Surgery Institute, and Southern California Vein & Artery Specialists, Inc) of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. If my insurance plan requires an authorization or referral, and I do not obtain one for the services I receive, I understand that I am responsible for all charges, even if the provisions of my plan stipulate I otherwise wouldn't be. I authorize any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agree to the above.

Signature: \_\_\_\_\_

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**■ Other Medical Providers**

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_  
Pharmacy Address \_\_\_\_\_

**■ Health Problems**

|                                    | <u>Yes</u>               | <u>No</u>                |  | <u>Yes</u>               | <u>No</u>                |
|------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Stroke .....                       | <input type="checkbox"/> | <input type="checkbox"/> | Allergies .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease .....                | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack .....                 | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice / Hepatitis .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever .....              | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema .....                    | <input type="checkbox"/> | <input type="checkbox"/> | Cancer .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis .....                 | <input type="checkbox"/> | <input type="checkbox"/> | Back Problems .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumonia .....                    | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding / Clotting Problems ..... | <input type="checkbox"/> | <input type="checkbox"/> | Stomach / Ulcer Problem .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech / Hearing Problems .....    | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ .....                  | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion (Dates: _____) ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**■ Previous Surgeries** *Circle all that apply, and list date(s)*

|                           |       |                           |       |
|---------------------------|-------|---------------------------|-------|
| Ear / Nose / Throat ..... | _____ | Hysterectomy .....        | _____ |
| Appendectomy .....        | _____ | Hernia .....              | _____ |
| Eye .....                 | _____ | Hemorrhoid .....          | _____ |
| Breast .....              | _____ | Back / Neck .....         | _____ |
| Gallbladder .....         | _____ | Joints (Hip / Knee) ..... | _____ |
| Heart / Bypass .....      | _____ | Carotid Surgery .....     | _____ |

Balloons or stents in blood vessels: If yes, which locations and dates? \_\_\_\_\_

Aneurism surgery: If yes, open or closed, and which locations and dates? \_\_\_\_\_

Other hospitalizations: List reasons and dates \_\_\_\_\_

**■ Family History**

|                           | <u>Yes</u>               | <u>No</u>                |                    | <u>Yes</u>               | <u>No</u>                |
|---------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|
| Heart Disease .....       | <input type="checkbox"/> | <input type="checkbox"/> | Cancer .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes .....            | <input type="checkbox"/> | <input type="checkbox"/> | Stroke .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure ..... | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ ..... | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

■ **Current Condition** Please answer these items as of today.

**Constitutional Symptoms**

- Good general health lately .....  Yes  No
- Recent weight gain.....  Yes  No
- Recent weight loss .....  Yes  No
- Fever .....  Yes  No
- Fatigue .....  Yes  No

**Eyes**

- Eye disease or injury .....  Yes  No
- Wears glasses or contact lenses.....  Yes  No
- Blurred or double vision .....  Yes  No
- Glaucoma .....  Yes  No

**Ears / Nose / Throat / Mouth**

- Hearing loss or ringing .....  Yes  No
- Earache or drainage.....  Yes  No
- Chronic sinus problem / rhinitis .....  Yes  No
- Nose bleeds .....  Yes  No
- Mouth sores .....  Yes  No
- Bleeding gums .....  Yes  No
- Bad breath or taste in mouth.....  Yes  No
- Sore throat .....  Yes  No
- Voice change .....  Yes  No
- Swollen glands in neck.....  Yes  No

**Cardiovascular**

- Heart trouble .....  Yes  No
- Chest pain or angina pectoris .....  Yes  No
- Palpitations.....  Yes  No
- Short of breath when walking.....  Yes  No
- Short of breath when lying down.....  Yes  No
- Swelling of feet, ankles or hands .....  Yes  No

**Respiratory**

- Chronic or frequent cough.....  Yes  No
- Spitting up blood .....  Yes  No
- Shortness of breath.....  Yes  No
- Difficulty breathing.....  Yes  No
- Sneezing .....  Yes  No

**Psychiatric**

- Memory loss or confusion .....  Yes  No
- Nervousness .....  Yes  No
- Depression .....  Yes  No
- Insomnia.....  Yes  No

**Gastrointestinal**

- Loss of appetite .....  Yes  No
- Change in bowel movements .....  Yes  No
- Nausea or vomiting.....  Yes  No
- Frequent diarrhea .....  Yes  No
- Painful bowel movements.....  Yes  No
- Constipation.....  Yes  No
- Rectal bleeding or blood in stool.....  Yes  No
- Abdominal pain or heartburn .....  Yes  No
- Peptic ulcer (stomach or duodenal).....  Yes  No

**Genitourinary**

- Frequent urination.....  Yes  No
- Burning or painful urination.....  Yes  No
- Blood in urine.....  Yes  No
- Change in force or strain when urinating .....  Yes  No
- Incontinence or dribbling.....  Yes  No
- Kidney stones .....  Yes  No
- Sexual difficulty.....  Yes  No
- Men: testicle pain.....  Yes  No
- Women: painful periods .....  Yes  No
- Women: irregular periods .....  Yes  No
- Women: vaginal discharge .....  Yes  No

**Musculoskeletal**

- Joint pain .....  Yes  No
- Joint stiffness or swelling .....  Yes  No
- Weakness of muscles / joints .....  Yes  No
- Back pain .....  Yes  No
- Cold extremities .....  Yes  No
- Difficulty in walking .....  Yes  No

**Integumentary (skin, breast)**

- Rash or itching.....  Yes  No
- Change in skin color .....  Yes  No
- Change in hair or nails.....  Yes  No
- Varicose veins .....  Yes  No
- Breast pain.....  Yes  No
- Breast lump.....  Yes  No
- Breast discharge.....  Yes  No

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**■ Current Condition continued**

**Neurological**

- Frequent or recurring headaches.....  Yes  No
- Light headed or dizzy.....  Yes  No
- Convulsions or seizures.....  Yes  No
- Numbness or tingling sensation.....  Yes  No
- Tremors.....  Yes  No
- Paralysis.....  Yes  No
- Stroke.....  Yes  No
- Head injury.....  Yes  No

**Endocrine**

- Glandular or hormone problem.....  Yes  No
- Thyroid disease.....  Yes  No
- Diabetes.....  Yes  No
- Excessive thirst or urination.....  Yes  No
- Heat or cold intolerance.....  Yes  No
- Skin becoming drier.....  Yes  No
- Change in hat or glove size.....  Yes  No
- History of dialysis.....  Yes  No

**Hematologic / Lymphatic**

- Slow to heal after cuts.....  Yes  No
- Bleeding or bruising tendency.....  Yes  No
- Anemia.....  Yes  No
- Phlebitis.....  Yes  No
- Enlarged glands.....  Yes  No
- History of DVT.....  Yes  No
- History of pulmonary embolism.....  Yes  No
- Family history of clotting or bleeding disorder ....  Yes  No

**Allergic / Immunologic**

- Skin reaction or other adverse reaction to:
- Penicillin or other antibiotic.....  Yes  No
  - Morphine, Demerol or other narcotics.....  Yes  No
  - Novocaine or other anesthetics.....  Yes  No
  - Aspirin or other pain remedies.....  Yes  No
  - Tetanus antitoxin or other serum.....  Yes  No
  - Iodine, Merthiolate or other antiseptic.....  Yes  No
  - CT or MRI contrast injection.....  Yes  No



## POLICIES AND PROCEDURES

**Health Insurance Cards:** Please bring your most current health insurance membership card to each and every appointment. Intentionally failing to notify us of changes to your insurance coverage may constitute insurance fraud, and we may be obliged to report it to the authorities.

**Keeping Appointments:** Appointments must be cancelled with at least 1 full business day's notice for office appointments, and 3 full business days' notice for surgical procedures. Failure to show for an office visit, or cancellation on less than 24 hours' notice, constitutes a no-show and is subject to a \$50 fee. Failure to show for a surgical procedure, or cancellation on less than 3 days' notice, constitutes a no-show and is subject to a \$250 fee. Cancellation due to lack of referral (see below) is considered a no-show. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

**Health Insurance Plans:** Although we may advise you whether we believe we participate with your insurance carrier, we are not responsible for any assurances made to you regarding whether particular services rendered in this practice are covered by your plan. You and you alone are responsible to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your financial responsibilities and our participation status in your specific network.

**Referrals and Prior Authorizations:** You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). If you come to an appointment without a required referral, and you must reschedule, the canceled visit may be considered a no-show, as above.

**Medicare:** If you have coverage with original Medicare (this means Medicare directly from the government) or Medicare Advantage (this means Medicare provided through a commercial carrier) it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and a 20% coinsurance. Any portion of this deductible and coinsurance that is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitations, regardless of whether you are aware of the details. If you have both Medicare and another insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, and/or is not paid within 60 days from the date of service, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding this provision.

**In-Network Commercial Insurance:** If you have an insurance plan with which the provider does participate, and under which you have in-network benefits, we shall file claims with the insurance carrier and, upon receipt of carrier adjudication, will invoice you for any balance which may be applied to your financial responsibility. If your plan has a copayment, it is your responsibility to pay it in full at the time of service, even if the amount is not printed on your insurance card. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, you will be responsible to pay an invoice fee of \$15. If your insurance carrier advises us that the amount of your copayment is higher than what is printed on the card you provide, you are responsible for payment of the difference. If your plan advises us at any time that you do not have coverage for the services rendered, or your policy is exhausted, or you are not covered for services rendered for any reason, even retroactively, you will be responsible for the entire balance.

**Out-of-Network Commercial Insurance:** If you have an insurance plan with which we do not participate, but under which you have out-of-network benefits, we may agree to file claims for services rendered. You may be required to pay for some or all of the charges upfront toward your obligation for services rendered, and after receiving the insurance carrier adjudication we may bill you for the balance.

If your plan advises us at any time that you do not have coverage for the services rendered out-of-network, or your policy is exhausted, or you are not covered for services rendered for any reason, you will be responsible for the entire balance. If your

plan issues payment to us for services rendered out-of-network, you may be responsible for some or all of the balance, which we will invoice you for. If your plan makes payment directly to the patient or policy holder for services rendered, you are responsible to turn the entire payment over to us immediately upon receipt, by endorsing the check over to Southern California Multi-Specialty Center, along with a complete copy of the Explanation of Benefits. Should you be issued payment by the insurance carrier and not promptly turn it over to us in whole, legal action will be pursued and you may be discharged as a patient from this practice. After turning over the insurance carrier's payment, you may remain responsible for some or all of the balance, which we will invoice you for. We may only submit claims to your primary insurance – you may be given a receipt which you can submit to secondary insurance. Balance bills are due immediately upon receipt.

**Health Insurance Non-Payment:** Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. In cases of retroactive disenrollment, you are responsible immediately upon notification to us by the carrier. This policy applies equally to in-network and out-of-network plans. If your insurance carrier later makes payment on such a claim, you will be reimbursed for your payment, minus any amount which has been applied to your financial responsibility by your in-network insurance carrier.

**Balances and Collections:** It is our right and responsibility to bill you for any portion of your treatment your medical insurance assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance policy, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections. If that happens, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. If you bounce a check, you will be responsible for a \$35 fee, and will not be able to pay by personal check again. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

**Self-pay patients:** If you do not have health insurance, or are receiving services known to not usually be covered, it is our policy that you must pay for those services before leaving the office. If you have insurance through an out-of-network insurance to which we do not agree to submit claims on your behalf, you may ask for a receipt at the time of service.

**Smoke Free Environment:** Southern California Multi-Specialty Center is a smoke free environment. Smoking (including smokeless tobacco, electronic cigarettes and vaping, regardless of tobacco content) is prohibited at any of our locations.

**Weapon Free Environment:** Southern California Multi-Specialty Center strives to maintain an environment free from violence and intimidation. Weapons of any kind are prohibited on all our properties, with the exception of authorized law enforcement officers. For the purposes of this policy, weapons are defined as any implement or tool whose primary function is to cause bodily harm to the person against whom it is used.

**Laboratory Testing:** If you are a member of an insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office is so informed by you, we will happily send your specimens to that laboratory, unless the provider determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory, and shall handle financial matters directly with the laboratory.

**Privacy:** A person is liable for constructive invasion of privacy when they attempt to capture any type of visual image, sound recording or other physical impression of another individual engaging in a personal or familial activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than \$5,000 and not more than \$50,000 [California Civil Code, Section 1708.8]. Southern California Multi-Specialty Center complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

**I have read, fully understand, accept and agree to comply with all the above policies and conditions. I consent to the assignment of authorized health insurance benefits by my health insurer to Southern California Multi-Specialty Center (and its subsidiaries) for any services furnished to me or my dependents. I authorize any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original.**

Patient Name (Please print clearly): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

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



Southern California  
Multi-Specialty Center

Dr. Babak Eghbalieh (SoCal Hepatobiliary)  
Dr. Sammy Eghbalieh (SoCal Vein & Artery)

Central Office: 5805 Sepulveda Blvd # 690, Sherman Oaks CA 91411-2522

## PATIENT CONSENT TO PHOTOGRAPHY

The Department of Health and Human Services has established a provision known as the Privacy Rule, as a result of passage of the HIPAA law and its omnibus. It was created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of protected health information.

As our patient, we want you to know that we respect the privacy of your personal medical records, and will take all reasonable efforts to secure and protect that privacy in compliance with the law. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your healthcare information and information about treatment, payment, or healthcare operations, to provide healthcare that is in your best interest. Part of your treatment may include photographs and/or video of your face and other body parts. We may also desire to use the photographs and/or video taken of you by our office for treatment and educational purposes. However, prior to using any photographs and/or video we will obtain consent from the patient, parent, or legal guardian.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any concerns about this policy or form, please ask to speak with our HIPAA Compliance Officer.

### INFORMED CONSENT TO PHOTOGRAPH

I, (print name of patient or legal guardian) \_\_\_\_\_ do hereby give consent to Southern California Multi-Specialty Center, and its subsidiaries, to take and/or display photographs and/or video of the patient's face and other body parts. The photographs or video will be used as part of medical information and educational purposes by Southern California Multi-Specialty Center and/or its subsidiaries, and may also be displayed within the office and/or the office's webpage. The doctors and office staff will protect my personal data, such as name, age and date of birth, from being displayed.

I further understand that if the photograph(s) and/or video are used, I do not expect compensation, financial or otherwise, of the use of these photographs and/or video, and waive all such rights.

Patient Name (please print clearly): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Relationship: \_\_\_\_\_



# PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

◆ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

◆ I agree that telephone messages regarding my appointments, prescription renewals, test results, and all other Protected Health Information\* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ Home / Office / Cell / Other: \_\_\_\_\_

( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ Home / Office / Cell / Other: \_\_\_\_\_

( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ Home / Office / Cell / Other: \_\_\_\_\_

◆ I agree that my PHI may be shared with my spouse (if applicable).

◆ I agree that my PHI may be shared with my other medical providers.

◆ I agree that my PHI may be shared with the following other people:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

◆ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Southern California Multi-Specialty Center to the attention of the HIPAA Compliance Officer.

◆ I agree that Southern California Multi-Specialty Center and its subsidiaries may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

*\*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (Please print clearly): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_





Southern California  
Multi-Specialty Center

Dr. Babak Eghbalieh (SoCal Hepatobiliary)

Dr. Sammy Eghbalieh (SoCal Vein & Artery)

Central Office: 5805 Sepulveda Blvd # 690, Sherman Oaks CA 91411-2522

# MEDICAL RECORDS RELEASE

I hereby request protected health information to be released from the medical record of:

**Patient Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Release Records From:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Send Records To:**

Southern California Multi-Specialty Center  
5805 Sepulveda Boulevard  
Suite 690  
Sherman Oaks CA 91411-2522  
Fax: (818) 900-6488

**This request and authorization applies to:** *(check appropriate selection)*

All healthcare information.

Only healthcare information relating to the following treatment, condition or date(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I hereby authorize and request the prompt release of medical records without exception, including but not limited to clinical notes, lab tests, pathology reports, radiology reports, messages, prescriptions, consultations and secondary records.**

Patient Name (Please print clearly): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_