Arroyo Oaks Medical Associates Inc. - For Dr Aswani Only

2230 Lynn Rd Suite 200
Thousand Oaks Ca. 91360
Phone: (805) 495-1066
Fax: **(805) 852 2678**

www.arroyo-oaks.com/contact-us

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Account_____ _____

_____ _____
Print Patient's Full Name Birth Date (Mo/day/Yr)

_____ _____
Street Address Social Security Number (last 4 digits)

_____ _____
City, State, Zip Code Phone

At the request of the individual, I _____
(Patient's Name)

Hereby authorize:

_____
Name of company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip Phone

_____
Fax

To release medical records to:

Manoj Aswani MD FACP
Upload to Web-portal / Scan QR with
Attn to: Dr Aswani

Or Fax Records: (805) 852 2678
Address: 2230 Lynn Road, STE 200
Thousand Oaks, CA 91360

____ Discharge Summary ___ Pathology Reports ____ Emergency Reports
____ History & Physical ___ Laboratory Reports ____ X-Ray
____ Progress Notes ___ Radiology Reports ____ Other
____ Operative Notes ___ ECG/EEG/Cardiac Cath _____
____ I do ____ I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

___ Referral to Specialist ___ Insurance ___ Workers' Comp
___ Legal Investigation ___ Disability Determination ___ Personal
___ Change of Doctor ___ Other (Specify) _____

Please provide DAYTIME telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 DAYS from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual (or guardian or Personal Representative of patient's state) Date

NOTE: THERE WILL BE A $25 CHARGE FOR A PERSONAL COPY OF THE PERMANENT-TRANSFER OF YOUR RECORDS.
ARROYO OAKS MEDICAL WILL PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY