Authorization to Disclose Protected Health Information FROM
Maansi Family Health Center, Dr Khivan Oberoi & Dr Molly Rubens

Patient Name _____ DOB ___/___/___ Phone _____

Address _____
Street *City* *State* *Zip*

I hereby authorize:

Dr Khivan Oberoi & Dr Molly Rubens
960 Liberty St SE, suite 201 Salem OR 97302
P: 503 893 8905 F: 503 828 9593

To disclose my medical information to:

_____ Phone/Fax _____
Doctor/Medical facility

By checking next to the options below, I authorize the release of the following medical records:

☐ Chart notes
☐ Laboratory Reports
☐ Imaging Reports Other: _____

for the purposes of medical management and follow up care.

As required by Privacy Regulations, Maansi Family Health Center may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I understand the purpose of this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release.
This request is entirely voluntary on my part. I am aware that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 180 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ _____
Printed Name of Patient Signature Date

_____ _____ _____
Printed Name of Legal Guardian Signature Date