ALI MAKKI, DMD

Headache and Facial Pain Disorders
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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the following entity to disclose copies of my protected health information to Dr. Ali Makki: Facility Name/Person Address Phone Number Fax Number Patient Name (first/middle/last) Date of Birth (mm/dd/yyyy) Social Security Number Date(s) of Service INFORMATION TO BE RELEASED: ☐ Clinical Notes ☐ Imaging Report(s) ☐ Lab Report(s) ☐ Other **RECORDS COPY DELIVERY:** ☐ Fax to **(949) 229-6226** ☐ Mail to 41 Creek Road, Suite 340, Irvine, CA 92604-4724 The above information is to be released for the following purpose only: ☐ I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided in the regulations. ☐ I hereby authorize the release of any records containing alcohol/drug abuse, AIDS/HIV status and/or testing and psychiatric diagnosis. My authorization will expire ninety (90) days from the date of my signature or as otherwise specified by date, Event, or condition as follows: I understand I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as described below. Signature of Patient or Legal Representative Date (mm/dd/yyyy)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates the provision of this law shall be fined not more than \$500 in the case of a first offense and not more than \$5,000 in the case of each subsequent offense.

Phone Number

Relationship to Patient