ENCINO VASCULAR INSTITUTE

FARSHAD MALEKMEHR, M.D., F.A.C.S.
CARDIOTHORACIC & VASCULAR SURGERY
Encino, CA 91436 and Valencia, CA, 91355 TEL: (818) 908-9752 FAX: (661) 799-745

ASSIGNMENT OF BENEFITS, HIPPA, PRIVACY PRACTICE, MEDICAL TREATMENT, AND AUTHORIZATION OF RELEASE OF INFORMATION

Please initial

_____ I authorize Dr. Farshad Malekmehr to medically treat and prescribe medication pertaining to my medical needs and diagnosis.

_____ I hereby assign to Dr. Farshad Malekmehr all monies to which I am entitled for medical and/or surgical expense relative to the service reported. I understand I am financially responsible for charges not covered by this assignment or my coverage. Additionally, any legal fees or collection expenses to settle this account will be my responsibility.

_____ I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by the physician and staff, which they may deem advisable and agree to pay all charges incurred by reason thereof.

_____ I authorize release of information requested by any healthcare insurance company and/or their staff in which I may be enrolled. I fully understand that this agreement and consent will continue until cancelled by me in writing.

_____ I acknowledge that I have received a copy of the Privacy Practices and HIPPA notice from Dr. Farshad Malekmehr's office.

Dr. Farshad Malekmehr and staff can disclose my medical information to the following people:

Name	Relation	Phone Number

My signature below confirms that I have read and initialed the above information entirely.

Signature: _____

Printed Name: _____

Date: _____