KHOOBEHI

Patient Information:	Patient Full Name (print):	DOB:
	Address (City, State and Zip Code):	
	Phone Number:	Email Address:
Health Information Released From:	□ Khoobehi & Associates 3901 Veterans Blvd., Metairie, LA 70002 4500 Magazine Street, Suite 1, New Orleans, LA 70115	Metairie: Phone: 504-779-5538 Fax: 504-779-5399 New Orleans: Phone: 504-304-1248 Fax: 504-617-7879

Health Information Released To:	□ Name of Organization/Clinic **- OR –** □ Self	Attn:
	Address (City, State and Zip Code):	
	Phone Number:	Fax Number:
	E-mail Address (if to be sent by email):	

Health Information To Be Released:	□ Specific Date/Year of Treatment _____ □ Images □ Operative Report □ Billing Statement □ Injection Notes □ Lab Reports □ Doctor Notes □ Other _____
Delivery Method:	□ U.S. Mail to the person and at the address indicated in the "Health Information Released To" section above □ Email to the address indicated in the "Health Information Released To" section above □ Fax at the number indicated in the "Health Information Released To" section above □ In-person pick up at the Khoobehi & Associates office location noted here: _____

_____ _____ _____

Print Name Signature Date

Personal Representative's authority to sign: □ Patient is a Minor □ Power of Attorney or Legal Representative □ Other _____

Released By (Print): _____ Released By (Signature): _____ Date:_____