Multiple Sclerosis Center of California®
Daniel S. Bandari, M.D, Inc.

AUTHORIZATION TO DISCLOSE & DISCUSS MEDICAL INFORMATION WITH THIRD PARTIES

Patient Name (Print):_____ Date of Birth: _____

I am the ____ Patient ____ Guardian ____ Conservator ____ Designee **and hereby authorize MS Center of California and Daniel S. Bandari, MD. Inc. to disclose specific medical information as indicated below to:**

Name:

Relationship:

Phone / Fax numbers:

Notice: Unless specified below, this authorization is for full disclosure of all records, including clinical findings, diagnosis, treatments, assessments, recommendations for further care, names of all healthcare personnel, dates of hospitalizations and ambulatory services.

Type of discloser:

___A. **Full disclosure**- Verbally providing/ discussing medical condition, including any results and medical records as requested.

___B. **Limited disclosure**- Only medical records and/or specifications:

_____

I understand that this consent is only for the specific purpose stated and may be revoked at any time by the patient.

Patient Signature_____ **Date**: _____

Signature of Parent/Guardian (if applicable): _____Date: _____