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AUTHORIZATION TO RELEASE PSYCHIATRIC AND MEDICAL INFORMATION

I _____ , born on _____

hereby authorize Sayeh Beheshti, M.D. to release my information and/or records specified below to _____

_____

Please release the information to the following (enter address or fax number):

_____

_____

RECORDS AUTHORIZED AND REQUESTED TO BE RELEASED:

- ☐ My chart in its entirety which includes all of the items listed below, or only
  - ☐ Initial evaluation
  - ☐ Progress notes
  - ☐ Office notes
  - ☐ Telephone correspondence
  - ☐ Email correspondence
  - ☐ Information forwarded to you by other health care providers
  - ☐ Laboratory reports
  - ☐ Medication Logs
  - ☐ Records pertaining to drug or alcohol abuse and/or recovery
  - ☐ Complaints or grievances filed, with responses or dispositions
- ☐ Other : _____

This information will be used for the purpose of _____

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THE SIGNATURE BELOW.

I UNDERSTAND THAT

- I can revoke this authorization at any time by writing to my provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.
- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.
- My information will be released ONLY to the specified recipient, and that the recipient is obligated by HIPPA laws to keep the released data confidential, and is prohibited by HIPPA laws to distribute, copy, or in any way share this information with any person or entity not listed in my handwriting above.

SIGNATURE : _____ DATE : _____