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AUTHORIZATION TO RELEASE PSYCHIATRIC AND MEDICAL INFORMATION

I _____ , born on _____

hereby authorize my provider _____

at fax number _____ to release my information and/or records specified below to Sayeh Beheshti, MD.

PLEASE RELEASE THE INFORMATION IN THE FOLLOWING FORMAT:

- ☐ Upon request in person to myself
- ☐ By fax to (949) 706-5254
- ☐ By mail to 366 San Miguel Drive, Suite 310, Newport Beach, CA 92660

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 continuity of care with Dr. Beheshti.
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

SIGNATAURE : _____ DATE : _____