Shahin Sakhi, M.D., Ph.D.

Print Form

2100 Sawtelle Blvd., Suite #107, Los Angeles, CA 90025

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

This authorization for use of disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 et. seq.

Patient Name _____ Date of birth _____

I hereby authorize: _____
Name of Agency/Person/Organization

Address of Agency/Person/Organization _____ Telephone number _____

to release to Dr. Shahin Sakhi written and oral information which pertains to the

☐ Medical ☐ Psychiatric/Psychological ☐ Drug & Alcohol ☐ School ☐ Other _____

assessment and/or treatment of the patient for the treatment period of _____ (from) - _____ (to)

OR ☐ any and all records

☐ I hereby Authorize Dr. Shahin Sakhi to release to the above indicated Agency, Person, or Organization written and oral information pertaining to Medical and Psychiatric assessment and/or treatment of the patient during the period under Dr. Sakhi's treatment.

My signature below acknowledges my understanding and authorization and consent for the following:

1. This RELEASE OF PATIENT INFORMATION AUTHORIZATION is vailid for 90 days if not revoked earlier.
2. This authorization covers both the release of that informations specified above presently compiled and information to be compile during the course of the patient's outpatient treatment.
3. Use of this authorization form may reveal or imply that mental health services have been/are being provided to the patient.
4. This authorization is subject to my revocation at amy time except for information already released.
5. I understand that I have a right to receive a copy of this authorization.
6. A copy of thhis form is as valid as the original
7. I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifally required or permitted by law.

_____
Patient/Representative/Spouse*/Financially Responsible Party*

_____ Date _____
Signature of Patient/Representative/Spouse*/Financially Responsible Party*

_____ Date _____
Witness to Above Signature

*A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insrance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.

REVOCATION OF AUTHOZIZATION FOR RELEASE OF PATIENT INFORMATION

WRITTEN REVOCATION: I hereby revoke my authorization for the above specified information.

_____ Date _____
Signature of Patient/Parent/Guardian

ORAL REVOCATION: Parent/Guardian revoked the authorization for the above specified patient.

_____
Means of Revocation