

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

Copies of the signed authorization will be considered as valid as the original.

I hereby authorize

NAME OF DISCLOSING PARTY

ADDRESS

CITY STATE ZIP PHONE FAX

Nikki Banh, M.D. / Nazzi Mojibi, M.D.

To disclose to

NAME OF RECEIVING PARTY

7055 N. Chestnut Ave. #106

ADDRESS

Fresno CA 93720 (559) 797-4400 (559) 797-4401

CITY STATE ZIP PHONE FAX

Records and information pertaining to:

NAME OF PATIENT (LIST OTHER NAMES USED)

DATE OF BIRTH

ADDRESS CITY STATE ZIP PHONE

DURATION: This Authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature.

REVOCACTION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon the Authorization.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

RECORDS: All medical information _____ **(initial)** A separate authorization is required for HIV disclosure or psychotherapy notes.

Specify the records to be disclosed:

The requester may use the health information authorized on this form for the following purposes only:

I understand that I have the right to receive a copy of this authorization.

_____/_____/_____
Patient/ Legal Representative/Guardian Relationship to Patient DATE