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HIPAA Compliant Authorization Form
**** Authorization for Use or Disclosure of Protected Health Information**
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R;. Parts 160 and 164) **

I authorize _____(healthcare provider / group)

Fax number:_____to use and disclose the protected health information described below to ***Annie A. Barseghian, M.D. fax: (626) 226-5923***

This protected health information includes information contained in my medical records, which may include, and may not be limited to my medical history, laboratory results, radiology results, and my physician's diagnosis for treatment. I understand the information to be released or disclosed may include information relating sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization shall be in full force and effect for 180 days at which time this Authorization for Use and Disclosure of Protected Health Information expires.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditions on whether I sign this authorization

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date