A. Reza Moattari
Endocrinology, Diabetes, Metabolism
1441 Avocado, Suite 807
Newport Beach, CA 92660
Phone 949.706.7706 Fax 949.706.7707

AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date Of Birth: _____

I hereby authorize _____ to release and disclose the health information of the above named patient as described below to:

A. Reza Moattari
1441 Avocado, Suite 807
Newport Beach, CA 92660

I understand that the health information to be released, as described below, may include information concerning drug or alcohol abuse, mental, health or HIV test results; and I specifically consent to the release and disclosure of any such information relating to drug or alcohol abuse, mental health, and HIV test results. I understand that this authorization does not apply to psychotherapy.

Health information to be released [check all that apply]

? Entire Medical Record
? Medical History
? Diagnostic test results/report
? Surgical/Operative Reports
? Other _____

This information may be used and disclosed for the following purpose:
_____

This authorization is effective immediately and shall remain in effect until _____. I understand that I have the right to revoke this authorization at any time. I further understand that if I revoke this authorization, it will apply to information that has already been released pursuant to this authorization.

I understand that treatment, payment, enrollment or eligibility for benefits cannot be conditioned on my signing this authorization.

I understand that once information is released and disclosed pursuant to this authorization, unless protected under California law, it may redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization form after it is signed.

I certify that I am the patient or the patient's personal representative and am authorized to sign this form.

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____
If patient's personal representative, attach a copy of legal authority.