ALAIN KARAGUEZIAN M.D.

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AUTHORIZATION FORM

Patient's Full Name	Patient's SSN / Medical Record Number
Address	Patient's Date of Birth
City, State, Zip Code	Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   _____
   His / Her Name

   _____
   Address

   _____
   City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

   _____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: ☐ Y ☐ N Disclose this information*

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual*	Date of Individual Signature	DOB or SSN
Signature of Guardian* or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative Signature	Description of Authority to Act for the Individual
Received By	Processed By	Log #