AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone number: _____ Social Security #:_____

I request and authorize _____to release healthcare

information of the patient named above to:

Name: ***Dipti Doshi, MD Inc.***
Address: ***17100 Norwalk Blvd, Suite #101/#103***
City: Cerritos State: ***CA***
Zip Code: ***90703***

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or

dates:_____

□ All healthcare information

□

Other:_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL,
chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of my labs results to the voicemail listed above.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that I may refuse to sign this authorization or revoke this authorization at any time by giving written notice to Advanced Arthritis and Rheumatology Center. I understand that authorization can be revoked or terminated by submitting a written revocation to Dipti Doshi MD Inc.. I understand that I should contact the privacy officer to terminate the privacy authorization. I understand that my revocation or refusal to sign this authorization form will not

affect my ability to obtain health care services or payment or my eligibility for benefits. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing. I understand as a patient I have the right to access my records during business hours. Copies of the records may be obtained with reasonable notice and payment of printing cost. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations. A photocopy or exact reproduction of this signed authorization shall have the same force and effects as the original.

Signature: _____ Date:_____

Record Release Date: _____ Staff Name:_____