Family Allergy
Asthma, Immunology & Sinus Center

Dr. Maryam Zarei

15725 Pomerado Road, # 103 Poway, CA. 92064 T: (858) 521-0806 F: (858) 521-0808

Record Release Form
Authorization for Use of Disclosure of Health Information

Authorization for Use/ Disclosure of Information: I voluntarily authorize and direct the health care provider name below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: _____

Address of Provider: _____

_____

Phone Number: _____ Fax Number: _____

Recipient and Address for Delivery: Family Allergy, Asthma, Immunology, & Sinus Center P.C. / Dr. Maryam Zarei
15725 Pomerado Road, Suite # 103
Poway, Ca. 92064
Tele #: 858-521-0806, Fax #: 858-521-0808

Medical records and information pertaining to medical history, mental or physician condition, services rendered, or treatment

For: _____ **DOB** _____.
(Print last, first, middle initial)

- o ALL MEDICAL INFORMATION, WITHOUT EXCEPTION, including information regarding AIDS testing, psychological or psychiatric treatment, and drug or alcohol abuse.
- o All medical information described above **EXCEPT** for the following:
  _____
- o ONLY THE FOLLOWING INFORMATION:
  _____.

USES:
This information supplied is to be used for the follow purpose(s):

_____.

DURATION:
This authorization shall become effective immediately and shall remain in effect until revoked.

I UNDERSTAND that I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or by my legal representative and delivered to Family Allergy, Asthma, Immunology, & Sinus Center P.C.

My revocation will be effective upon receipt, but will not be effective to the extent that that requestor or other have acted in reliance upon Authorization. I have the right to receive a copy of this authorization. I will not be required to sign this Authorization as condition to obtain treatment of payment or my eligibility of benefits.

SIGNATURE:

Signed: _____ Date: _____

Relationship to Patient: _____ Witness: _____

California law prohibits the requester from making further disclosure of health information unless the requester obtains another authorization from me or unless such disclosure is specifically required or permitted by law.
** Please note that there may be a charge for copying records.