Family Allergy
Asthma, Immunology & Sinus Center

Dr. Maryam Zarei

15725 Pomerado Road, # 218 Poway, CA. 92064 T: (858) 521-0806 F: (858) 521-0808

Authorization for Use and Disclosure of Health 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 following recipient.

Sender: Physician/Healthcare Facility: _____
Address: _____
Phone Number: _____ Fax Number: _____

Recipient:

Maryam Zarei, M.D. F.A.A.A.I.
Diplomate of the American Board of Allergy and Immunology
Family Allergy, Asthma, Immunology and Sinus Center (FAAISC)
15725 Pomerado Rd. #103 Poway, CA 92064
Phone Number: (858)521-0806 Fax Number: (858)521-0808

USES:
This information is to be used to establish as a new patient and/or transfer of care.

- THE FOLLOWING INFORMATION:
  - o Last office note____
  - o Imaging (CXR, Chest CT, Sinus CT) ____
  - o Allergy Testing ____
  - o Allergy Shot Recipe/Records ____
  - o Blood work ____
  - o Pulmonary Function Test____
  - o Substance Abuse _____
  - o Mental Health _____
  - o HIV Testing_____
  - o Genetic Testing _____
  - o Other _____

Family Allergy
Asthma, Immunology & Sinus Center

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

RESTRICTIONS: 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 FAAISC.

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained by me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization will be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

SIGNATURE:

_____ _____

Signature of patient *or legal/personal Representative*

Relationship *if other than Patient*

_____ _____

Patient's Name (PRINT)

Date

_____

Patient's Date of Birth

_____ _____

Witness' Name (PRINT)

Witness Signature