Arsalan Malik, MD, Inc., 2730 Wilshire Blvd, Suite 630, Santa Monica, CA 90403

Authorization to Use/Disclose Health Care Information

Patient Name: ____ **Birth date**: ___________

Maiden or other name (if applicable)____

I request and authorize ____________________________________ to release the health care information described below to:

Name: ____ at ____________

Address:
____

City, State: ____________________________________ **Zip code**: ______________

This request and authorization applies to only the following protected health information:
____ HISTORY / PHYSICAL EXAM _____ LABORATORY REPORTS _____ CONSULTATIONS
____DISCHARGE SUMMARY _____ DOCTOR'S ORDERS _____ PROGRESS NOTES
____PSYCHIATRIC REPORTS / TESTS _____ PSYCHOLOGICAL REPORTS _____BILLING RECORDS
____INITIAL PSYCHIATRIC EVALUATION _____ OTHER

____
during the following time period or dates: ___________________________

Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Purpose(s) of this use/disclosure:____

Authorization expires: ____(date or event, e.g., "end of research study")

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Arsalan Malik, M.D.

I understand that Dr. Malik may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research. I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient or authorized representative)____

Date: ___________________

Relationship/authority (if signed by authorized representative):____________________________

I have received a copy of this signed authorization: (please initial) ___ yes ___ no