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- Alfred Valles, M.D., F.A.C.C., F.S.C.A.I.
- Jagroop Basraon, D.O.
- Jaswant Basraon D.O., M.P.H
- Shaukat Ali M.D., F.A.C.C.
- Shradha Rathi, M.D.
- Usman Javed, M.D, F.A.C.C.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I Hereby Authorize:

NAME OF DISCLOSING PARTY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

to disclose to:

NAME OF RECEIVING PARTY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Records and Information Pertaining to:

NAME OF PATIENT (LIST OTHER NAMES USED) _____	MEDICAL RECORD NUMBER _____	DATE OF BIRTH _____
ADDRESS _____	TELEPHONE NUMBER _____	

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of the signiture. DATE

REVOCAATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of information is to be disclosed.

<input type="checkbox"/> MEDICAL INFORMATION	<input type="checkbox"/> PSYCHIATRIC INFORMATION	<input type="checkbox"/> RESULT OF HIV BLOODTEST
_____ INITIAL DATE	_____ INITIAL DATE	_____ INITIAL DATE
<input type="checkbox"/> DRUG/ALCOHOL INFORMATION	<input type="checkbox"/> OTHER HEALTH INFORMATION	
_____ INITIAL DATE	_____ INITIAL DATE	

Specify the records to be disclosed: _____

Patient Signature: _____ **Date:** _____