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

I hereby authorize:

_____

Name of disclosing party (**Hospital or Doctor**)

_____

Address:

_____

City State Zip

to disclose to:
Maia U. Chakerian, MD

360 Dardanelli Lane Suite 2G

Los Gatos, Ca 95032

Phone: _____Fax:_____

Records and information pertaining to:

_____ _____

Name of Member/**patient** (Please print) Date of Birth

_____

Address

_____ _____

Telephone number

DURATION: This authorization shall become effective immediately and shall remain in effect from the date of signature unless a different date is specified here_____ (date).
REVOCATION: This authorization is also subject to written revocation by the patient at any time the written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
REDISCLOSURE: I understand that the recipient 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 RECORDS: Initial/or sign to specify which type of information is to be disclosed.

- ☐ **MEDICAL INFORMATION** _____ (initial)
- ☐ **PSYCHIATRIC INFORMATION** _____ (initial)
- ☐ **DRUG/ALCOHOL INFORMATION** _____ (initial)
- ☐ **OTHER HEALTH INFORMATION** _____ (initial)

Specify the records to be disclosed:

_____

A copy of this authorization is as valid as the original. Patient has a right to a copy of this authorization.

_____ _____

Date Signature

_____

If signed by other than patient, indicate relationship

Maia U. Chakerian, MD
Board Certified in Anesthesiology & Pain Medicine/American Board of Anesthesiology
360 Dardanelli Lane, Suite 2G
Los Gatos, CA 95032
408-356-0503 Extension 2006

IF POSSIBLE PLEASE FAX RECORDS TO 408-356-4704
Attn: Stephanie West, Clinical Research Coordinator