Release of Health Information

Patient Name:_____

Patient DOB:_____ SSN:_____

I request and authorize _____ to release health care information to :

Physician:	Lisa B. Arian, MD
Address:	7930 Frost Street, Suite 104 San Diego, CA 92123
Phone:	(858) 277-0696
Fax:	(858) 277-0690

The request and authorization applies to:

_____ Health care information relating to the following treatment, condition or dates of treatment:_____

_____ All health care information

_____ Other:_____

_____ DO NOT RELEASE THE FOLLOWING INFORMATION:_____

_____

I understand that my express consent is requited to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health, drug and/or alcohol use. I understand this authorization may include such medical information, unless specifically limited by myself.

I understand that I have the right to withdraw this authorization at any time and that such revocation must be in writing. This authorization shall expire in 90 days.

_____ _____

Signature of patient or representative Date

For Office Use Only

Faxed/Mailed on:_____

To:_____

_____