AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient Name: ______________________________ DOB: __________ SS#: ________________

I authorize Marianne Zakarian, M.D. to use or disclose Protected Health Information (PHI) contained in my medical records in the following manner:

From: ____
Physician/Institution that presently has data

____
Street Address

____
City State Zip Phone Fax

To:

Release the following Protected Health Information:
____ All records ____ Chart notes ____ X-rays ____ Lab ____ Sustance Abuse Info. ____ HIV ____ Mental Health

Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information.

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The Protected Health Information is being used or disclosed for the following purpose(s). If the patient is requesting the release, this may sate "at patient's request.

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I understand that I have the right to revoke this authorization in writing by sending notification to:

Marianne Zakarian, M.D.
2536 N. Stokesberry Place
Meridian, Idaho 83646
(208) 855-0880
(208) 855-0889 (fax)

I understand that when I revoke this authorization, it is not effective to the extent that the clinic has already relied on the use or disclosure of the Protected Health Information. I understand the Protected Health Information is released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. The clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating Protected Health Information for disclosure to a third party (such as fitness for a work exam).
I understand that I have a right to inspect or copy the Protected Health Information being used or disclosed.
I understand that I have a right to refuse to sign this authorization.

____
Signature of Patient or Personal Representative Date

____
Printed Name of Patient or Personal Representative