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AUTHORIZATION TO RELEASE PSYCHIATRIC AND MEDICAL INFORMATION

I _____, born on _____
hereby authorize Sayeh Beheshti, M.D. to release my information and/or records specified below to _____

Please release the information to the following (enter address or fax number):

RECORDS AUTHORIZED AND REQUESTED TO BE RELEASED:

MY CHART IN ITS ENTIRETY WHICH INCLUDES ALL OF THE ITEMS LISTED BELOW, OR ONLY

INITIAL EVALUATION

PROGRESS NOTES

OFFICE NOTES

TELEPHONE CORRESPONDENCE

EMAIL CORRESPONDENCE

INFORMATION FORWARDED TO YOU BY OTHER HEALTH CARE PROVIDERS

LABORATORY REPORTS

MEDICATION LOGS

RECORDS PERTAINING TO DRUG OR ALCOHOL ABUSE AND/OR RECOVERY

COMPLAINTS OR GRIEVANCES FILED, WITH RESPONSES OR DISPOSITIONS

OTHER : _____

This information will be used for the purpose of _____

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THE SIGNATURE BELOW.

I UNDERSTAND THAT

- I can revoke this authorization at any time by writing to my provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.
- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.
- My information will be released ONLY to the specified recipient, and that the recipient is obligated by HIPPA laws to keep the released data confidential, and is prohibited by HIPPA laws to distribute, copy, or in any way share this information with any person or entity not listed in my handwriting above.

SIGNATURE : _____ DATE : _____