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AUTHORIZATION TO RELEASE PSYCHIATRIC AND MEDICAL INFORMATION

I _____, born on _____
 hereby authorize my provider _____
 at fax number _____ to release my information and/or records specified below to Sayeh Beheshti, MD.

PLEASE RELEASE THE INFORMATION IN THE FOLLOWING FORMAT:

UPON REQUEST IN PERSON TO MYSELF

BY FAX TO (949) 706-5254

BY MAIL TO 366 SAN MIGUEL DRIVE, SUITE 310, NEWPORT BEACH, CA 92660

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 continuity of care with Dr. Beheshti.

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

SIGNATURE : _____ DATE : _____