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

I hereby authorize:

____
____
Name of disclosing party

____
Address:
____
City State Zip

to disclose to:
Maia Chakerian, M.D., Sereno Pain Management Medical Group, Inc.
Name of recipient
695 Oak Grove Ave., Ste. 200
Address:
Menlo Park, CA 94025
City State Zip

Records and information pertaining to:

____
Name of Patient

____
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: Circle the records desired, initial/or sign to specify which type of information is to be disclosed.

MEDICAL INFORMATION
PSYCHIATRIC INFORMATION _________(initial)
DRUG/ALCOHOL INFORMATION
OTHER HEALTH INFORMATION

Specify the records to be disclosed and the dates to be included:
____

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 ________________________

Sereno Pain Management Medical Group
695 Oak Grove Ave., Ste. 200
Menlo Park, CA 94025
Phone: 650-666-2959/Fax: 650-600-8933