AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Directions: *Type or Print all requested information, with exception of signatures on Page 2.*

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's ID Number (Medicaid, SSN, Other)
Street Address			Individual's Date of Birth / /
City	State	ZIP Code	Phone ( ) -

I AUTHORIZE DR.DEBORAH BEUTLER TO SHARE MY HEALTH INFORMATION:

List the amount or type of information you would like to share in the section below.
For example, you can say all my health information or list certain types of information you would like to share.

DR.BEUTLER MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

GREGOR PARONIAN, MD

Name of Person/Organization

1713 E. WALNUT ST.

Street Address

PASADENA, CA 91106

City, State, ZIP Code

(626) 696 - 3607 — Phone Number

(626) 412 - 8765 — Fax Number

OR WITH THE FOLLOWING PERSON/PHYSICIAN OF MY CHOICE:

Name:

Phone Number: Fax Number: Email:

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- **Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above _____.**
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: *(list a date, event or condition)*

Date, Event or Condition
(Authorization will expire one year from the signature date if you leave this section blank.)

Signature of Individual or Legal Representative	Date / /
Name of Individual or Legal Representative	
Legal Representative's Relationship to Individual (i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)	

This authorization was revoked:

/ /

Signature Date

COMPLETION: Is voluntary, but required if disclosure is requested.