PONEH RAHIMI, MD
26732 CROWN VALLEY PARKWAY, SUITE #241
MISSION VIEJO, CA 92691
OFFICE: (949)364-2536 FAX: (949)388-8848

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

PATIENT'S NAME: ____

DATE OF BIRTH: ____

PATIENT'S SSN: ____

A.) PERSON(S) OR ORGANIZATION(S) AUTHORIZED TO PROVIDE INFORMATION:

- ✔ PONEH RAHIMI, MD
- ✔ MY INSURANCE CARRIER
- ✔ MY PRIMARY CARE PHYSICIAN AND/OR REFERRING PHYSICIAN
- ✔ OTHER (PLEASE LIST): ______________________________

B.) PERSON(S) OR ORGANIZATION(S) AUTHORIZED TO RECEIVE INFORMATION:

- ✔ PONEH RAHIMI, MD
- ✔ MY INSURANCE CARRIER
- ✔ MY PRIMARY CARE PHYSICIAN AND/OR REFERRING PHYSICIAN
- ✔ OTHER (PLEASE LIST): ______________________________

C.) INFORMATION THAT MAY BE USED OR DISCLOSED:

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D.) DESCRIPTION OF HOW THE INFORMATION MAY BE USED OR DISCLOSED:

1. TO PROVIDE PROFESSIONAL SERVICES TO ME, THE PATIENT
2. TO DISCLOSE/SHARE WITH OTHER HEALTH CARE PROFESSIONALS THAT ARE PROVIDING CARE/TREATMENT TO ME
3. TO PROVIDE MY INSURANCE CARRIER INFORMATION NEEDED TO PROCESS CLAIMS ON MY BEHALF FOR SERVICES PROVIDED TO ME
4. TO ASSIST IN THE NOTIFICATION OF A DESIGNATED FAMILY MEMBER, OR CONTACT PERSON, SPECIFIED BY ME, THE PATIENT, IN CASE OF AN EMERGENCY.

E.) Minors, HIV, psychiatric/mental health conditions, and alcohol/substance abuse

1. This disclosure does not contain patient medical information, if any, that is protected by special state and/or federal confidentiality laws and which cannot be disclosed without specific written consents.

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SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

____

PRINTED NAME OF PATIENT'S REPRESENTATIVE **RELATIONSHIP TO PATIENT**

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION (EXCEPT TO THE EXTENT THAT ACTION WAS ALREADY TAKEN IN RELIANCE ON THIS SIGNED AUTHORIZATION) AT ANY TIME BY NOTIFYING DR. PONEH RAHIMI'S OFFICE IN WRITING. I UNDERSTAND THAT I CAN REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT, PAYMENT OR MY ELIGIBILITY FOR BENEFITS (IF APPLICABLE). I UNDERSTAND THAT IF THE PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION IS NOT A HEALTH CARE PROVIDER OR PLAN COVERED BY FEDERAL REGULATIONS, THE INFORMATION DESCRIBED ABOVE MAY NO LONGER BE PROTECTED BY THESE REGULATIONS.