ANTHONY M. KASSIR, M.D.
A Professional Medical Corporation
120 Vantis, Suite 540
Aliso Viejo, California 92656
Diplomate, American Board of Psychiatry and Neurology
Fellow, American Psychiatric Association
Office (949) 360-9500
Facsimile (949) 360-9501

Authorization to Obtain and/or Release Medical Information

This authorization allows the healthcare provider(s) named below to obtain and/or release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance use disorders have special rules that require specific authorization.*

❑ OBTAIN MEDICAL RECORDS

I, the undersigned, authorize Dr. Kassir to **OBTAIN** the following medical information and records **FROM** the physician, individual, organization, agency, or entity specified below.

❑ RELEASE MEDICAL RECORDS

I, the undersigned, authorize Dr. Kassir to **RELEASE, DISCUSS, OR OTHERWISE PROVIDE** the following medical information and records **TO** the physician, individual, organization, agency, or entity specified below.

Information to be obtained and/or released by Dr. Kassir

That information regarding my medical history, illness/injury, consultation, prescriptions, treatment, diagnosis, prognosis, including imaging films or results (x-ray, CT, MRI, *etc*.); laboratory, ECG, and other test results; consent forms; prescription copies; billing information; correspondence and/or medical records, including those from other physicians, individuals, organizations, agencies, or entities possessed by the releasing party. Information may be released by means of mail, fax, or other electronic methods.

This authorization is:

❑ Unlimited (excluding Psychiatric/Mental Health; Drug, Alcohol, or Substance Use; HIV Tests/Diagnosis/Treatment; & Genetic Information)

❑ Limited to the following medical information:

_____

_____

_____

_____

_____

_____

_____

I also consent to the specific transfer of the following records

I authorize these information types to be OBTAINED by Dr. Kassir

Initial: _____ Psychiatric/Mental Health Information*

Initial: _____ Drug/Alcohol/Substance Use-related

Initial: _____ Tests for Antibodies to HIV

Initial: _____ HIV Diagnosis/Treatment

Initial: _____ Genetic Information

I authorize these information types to be RELEASED by Dr. Kassir

Initial: _____ Psychiatric/Mental Health Information*

Initial: _____ Drug/Alcohol/Substance Use-related

Initial: _____ Tests for Antibodies to HIV

Initial: _____ HIV Diagnosis/Treatment

Initial: _____ Genetic Information

* Psychiatric/Mental Health Information may contain psychotherapy notes if such notes are not kept separate from the rest of the psychiatric medical record as defined in the HIPAA regulations. Dr. Kassir does not routinely keep separate psychotherapy notes.

Records to be obtained from, and/or released to:

_____

Physician, Individual, Organization, Agency, or Other Entity

_____

Street Address

_____

City State Zip Code

(Phone) _____ (Fax) _____

For the purpose(s) of:

❑ Coordinating patient care ❑ Information exchange

❑ Other: _____

Duration
This consent is valid for a period of one (1) year from date signed.

Restrictions
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

I understand that this consent is effective immediately, and I have the right to revoke this consent at any time, except to the extent that Dr. Kassir or the above-named entity has already taken action in reliance upon it. I further understand any revocation will not become effective until written notice of such revocation has been received by the party or parties authorized to *release* information, at their regular office address, and it is my responsibility to ensure such receipt.

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.

Notice to Information Recipient
The recipient must destroy all information after its intended use, unless its confidentiality can be completely preserved (*e.g.* filed in a confidential and protected medical record).

Photocopy
I am advised of my right to receive a copy of this authorization upon request.

❑ Copy given to patient ❑ Copy offered but declined

Signature of patient or legal/personal representative

Print patient name

Patient date of birth

Relationship (if other than patient)

Date signed

Witness

Witness signature