Achillefs Ntranos MD P.C.

Authorization for Disclosure of Protected Health Information

I, the undersigned patient, hereby voluntarily authorize the disclosure or use of my health information as follows.

Disclosure Information

➔ *The information will be disclosed by:*

Achillefs Ntranos MD P.C.
9440 Santa Monica Blvd,
Suite 301 Beverly Hills, CA
90210

➔ *The information will be disclosed to:*

Practice Name: _____ Provider Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Purpose of Disclosure

➔ *The purpose or need for this disclosure is (mark all applicable and explain if necessary).*

☐ Patient Services: _____

☐ Marketing: _____

☐ Sale: _____

☐ Other: _____

Information Disclosed

➔ *The information to be disclosed from my record (mark all applicable)*

☐ Only information relating to:_____

☐ Only information for these dates: _____

☐ Other: _____

☐ Entire record*

Except for records relating to alcohol or drug use, sexually transmitted diseases, genetic testing, HIV/AIDS-related conditions, and psychiatric or mental health conditions. To authorize the disclosure of these records, check the applicable boxes below.

☐ The following records will not be disclosed without your express consent. Please mark any that you expressly authorize to be disclosed.

☐ Alcohol or drug use | ☐ Sexually transmitted diseases | ☐ Genetic testing

☐ HIV/AIDS-related conditions | ☐ Psychiatric or mental health conditions

Agreement and Acknowledgement

I understand that I may revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I provide an alternative expiration: _____.

I, the undersigned, hereby authorize the disclosure of my health information as I have indicated above by checking the applicable box(es), including, if checked, records relating to the following treatments or conditions: alcohol or drug use, sexually transmitted diseases, HIV/AIDS-related conditions, genetic testing, and psychiatric/mental health conditions.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient. Achillefs Ntranos MD P.C. will retain the original form.

Signature: _____ **Date:** _____

Name: _____

Prior Name(s): _____ ***(if applicable)***

Date of Birth: _____