Rena Ahuja MD
355 Placentia Ave. # 209 Newport Beach, CA 92663
Phone: 949.209.2789 Fax: 888.726.1822

AUTHORIZATION FOR USE/RELEASE OF HEALTHCARE INFORMATION:

NAME:_____ DOB:_____
I VOLUNTARILY AUTHORIZE AND direct the healthcare provider named below to disclose my health information during this term of this authorization to the recipient that I have identified below
Name/address of your prior and current doctors and fax number:

_____

TO RELEASE HEALTHCARE INFORMATION REGARDING THE PATIENT LISTED ABOVE TO:

Rena Ahuja MD
355 Placentia Ave. #209
Newport Beach, CA 92663
Fax: 888-726-1822

Purpose:
This request for authorization applies to: [**Please check the appropriate box.**]
◊ All Health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence and records from my other health care providers that the above-named health care provider may hold.
◊ All of my health information described above except for the following:

_____
◊ Only medical records relating to the following condition, treatment and date of treatment: _____

_____
◊ Other:_____
Re disclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
Refusal to sign/right to revoke: I understand that I may refuse to sign or revoke (at anytime) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my healthcare provider.
Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my healthcare provider at my healthcare provider's regular office address. The revocation will be

effective immediately upon my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this Authorization before the provider received my written notice of revocation.

Questions: I may contact my healthcare provider for answers to my question about the privacy of my health information at my healthcare provider's regular office telephone number. I understand that I have right to receive copy of this authorization from my healthcare provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Patient Signature:_____Date: _____

_____ _____

Print Signature of witness

If individual is unable to sign this authorization, please complete the information below.

_____ _____ _____

Signature of Personal Representative Legal relationship Date

_____ _____

Name (please print) Witness signature