KIRA STEIN, M.D. APC

TEL (310) 529-6051 • 433 N CAMDEN DRIVE, SUITE 600 • FAX (888) 959-0148
BEVERLY HILLS, CA 90210

AUTHORIZATION TO RELEASE & EXCHANGE INFORMATION

I, (individual's name)_____, hereby authorize the clinicians & staff of Kira Stein, MD, APC to **share the following information** with (name of person or entity) _____, who is (relationship):_____, and who can be reached at:

Telephone**:** _____ Email: _____

FAX:_____

Full Street Address:_____

Choose one (1) of these boxes

- ❑ Any and all of my health information that Kira Stein, MD APC has in their 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, other lab reports, and other mental health information (***excluding*** psychotherapy notes unless separately authorized), drug, alcohol or other controlled substance information, billing information, correspondence, psycho-diagnostic test reports, and communications from my other health care providers that Kira Stein, MD APC may hold.
- ❑ Any and all of my health information described above except for the following: _____
- ❑ Only the following records or types of health information (please give details): _____

1. The purpose of such disclosure is for use in connection with _____. The information and records released pursuant to this consent will not be used for any other purpose.
2. I understand that there is a risk that the person or entity receiving information or documents from Kira Stein, MD APC pursuant to this authorization may re-disclose the information and documents in a manner, which will no longer provide protection for the information and documents.
3. I understand that I may refuse to sign or may choose to revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Kira Stein, MD APC.
4. If I choose to revoke this Authorization in the future, the revocation will be effective immediately upon Kira Stein, MD APC receipt of my written notice, except that the revocation will not have any effect on any action taken by Kira Stein MD, APC in reliance on this Authorization before Kira Stein, MD APC received my written notice of revocation.
5. I understand that I may receive a copy of this authorization.
6. I understand that this release automatically expires one (1) year from today's date**, unless** I authorize the following expiration by checking the associated box:
   - ❑ I would like this authorization to expire only 180 days after my care at Kira Stein, MD APC has terminated.
   - ❑ I would like this authorization to expire on the following date: _____**.**

A scan, photocopy or facsimile of this signature is as valid as the original.

_____ _____ _____
Authorizing Individual's Name (printed) Authorizing Individual's Signature Date Signed

_____ _____ _____
Authorizing Individual's Phone Number Authorizing Individual's email Date of Birth

_____
Authorizing Individual's Mailing Address (number, street, Apt#, City, State, Zip)