Robin K. Dore, M.D. Inc
12791 Newport Ave., Suite 201, Tustin, CA 92780 ~ Tel: 714 505 5500 Fax: 714 505 3381

Authorization For Use or Disclosure of Protected Health Information

I hereby authorize **Robin K. Dore, M.D. and Robin K. Dore, M.D., Inc.**

12791 Newport Ave. Suite 201, Tustin CA 92780 (714) 505-5500 Fax (714) 505-3381

("Dr. Dore's practice") to use and disclose health information concerning patient

*[**Required:** PATIENT NAME]* **X**_____ as follows:

Health information to be used or disclosed: Any and all health information other than psychotherapy notes may be disclosed, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically written to the right: ***Optional**: Records not disclosed:* _____

Disclosure may be by means such as, but not limited to, providing copies of the records containing patient's health information, faxing such records and/or by allowing inspection and/or copying of such records by a copy service retained by the person to whom the information will be disclosed. We have no control over what the copy service or recipient does with your records.

*[**Required**: WHO GETS THE INFORMATION]*

This health information may be disclosed to: **X**_____

who may use this information only for the following purpose written below (for example, insurance, medical care, at the request of the individual, etc.)

*[**Required**: FOR WHAT PURPOSE]* **X**_____

I understand that I may revoke this authorization at any time by notifying Dr. Dore's practice in writing. My revocation will not affect actions taken by Dr. Dore's practice in reliance on this authorization prior to receipt of my revocation.

I understand that after Dr. Dore's practice discloses this health information to another person or entity, federal law (the HIPAA Privacy Rule) may no longer protect the privacy of this health information and it might be further disclosed.

Effect of Refusal to Sign Authorization: I understand that my (or the patient's named above if I am not the patient) health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now. It expires on: _____ if not revoked sooner. If no date is written in this blank, this authorization expires 1 year after the date it is signed. I understand that I have the right to receive a copy of this authorization.

SIGN NAME **X**_____

PRINT NAME **X**_____ **SIGNED ON / DATED** **X**_____

Patient: You must complete each blank that has an "X" MRR-From DD (2013)