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 **X**_____ (the "Health Care Provider") to use and disclose health information concerning the following patient:

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 below:

[optional]_____

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

This health information may be disclosed to:

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

who may use this information only for the following purposes written below – **examples**, medical care, insurance, at the request of the individual, etc.

X_____

I understand that I may revoke this authorization at any time by notifying the Health Care Provider in writing. My revocation will not affect actions taken by the Health Care Provider in reliance on this authorization prior to receipt of my revocation.

I understand that after the Health Care Provider 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 the following date: _____ if not revoked sooner. If no date is written in this blank, this authorization expires **1 year** after the date this authorization is signed.

I understand that I have the right to receive a copy of this authorization.

Signed: **X**_____ Print Name: **X**_____

Dated: **X**_____ Relationship if not Patient: _____