Authorization to Release Confidential Information

I, [Name of Patient] _____ ("Patient")
hereby authorize [Name of Provider] _____**SHIRIN SHAHROKHI** _____("Provider")
to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] **KAISER PERMANENTE** ("Recipient").

This Authorization permits the release of the following information:

___ Diagnosis ___ Treatment Plan ___ Progress to Date
___ Prognosis ___ Clinical Test Results ___ Dates of Treatment
___ Any and All Information Necessary
___ Other (specify)_____

I authorize the release of the information described above for the following purpose(s):

_____

_____

The specific uses and limitations on the types of information to be released are as follows:

_____

_____

The specific uses and limitations on the use of the information by Recipient are as follows:

_____

_____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until _____ ["Expiration Date"]

By: _____ Date: _____
(Patient or Patient's Representative)