SAED J. SAHOURI, M.D., PLLC

AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

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By signing below, I hereby authorize my health information, as more specifically described as the Protected Health Information, to be used or disclosed for the following purposes: _____

_____

The specific person or class of persons who are authorized to use or disclose my Protected Health Information are: Dr. Sahouri and his staff.

The person or class of persons to whom this office may use or disclose my Protected Health Information are:

_____

This Authorization shall expire on: _____

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:

- This office has taken action in reliance upon this Authorization; or
- This Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that I may revoke this Authorization by delivering written notice to Dr. Sahouri.

I understand that my Protected Health Information that is used or disclosed pursuant to this Authorization may be subject to re-disclosure by the person(s) you have disclosed it to, and the privacy of my Protected Health Information will no longer be protected.

I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my Protected Health Information in accordance with the terms of this authorization.

WITNESSES:

_____ _____

Patient Signature/Authorized Representative (state relationship) Date Signed