Victory Physicians
Frank B. Arian, M.D.

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________

Previous Name: ______________________________ Social Security Number: _______________

I request and authorize Frank Arian, M.D. a California Professional Corporation dba Victory Physicians to release my healthcare information to:

Name: ____

Address: ____

City: __________________________________ State: __________ Zip Code: ______

This request and authorization expires on ______________ and applies to:

☐ Healthcare information limited to the following treatment(s), or condition(s) or time period(s): _______

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☐ **All healthcare information and records which include but not limited to progress notes, laboratory and imaging reports, consultations, human immunodeficiency virus testing, sexually transmitted disease testing, psychological testing, mental health diagnosis and treatment, and drug/alcohol use, abuse or treatment(s).** ____

Patient Signature: ______________________________ Date Signed: ______________________

Witness Signature: _____________________________ Date Signed: ______________________

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