



Hematology · Oncology · Infusion Services
www.pacshoresoncology.com

1043 Elm Ave, #104
Long Beach, CA 90813
562- 590-0345
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222 W. Eulalia Street, #100-B
Glendale, CA 91204
818-637-7611
Fax: 818-637-5106

16300 Sand Canyon Ave, #207
Irvine, CA 92618
949-333-7580
Fax: 949-333-7599

3747 Worsham Ave, #101
Long Beach, CA 90808
562-430-5900
Fax: 562-799-8379

19582 Beach Blvd, #212
Huntington Beach, CA 92648
714-252-9415
Fax: 714-963-8407

351 Hospital Road, #610
Newport Beach, CA 92663
949- 999-1400
Fax: 949- 478-8185

Mojtaba Akhtari, MD • Mohamad Barakat, MD • Luke Chen, MD • Sassan Farjami, MD • Dilruba Haque, MD • Yaser Homsy, MD • André K.D. Liem, MD • Mark M. Ngo, MD
Danny Nguyen, MD • Eleonor T. Quan, MD • Sarmen Sarkissian, MD • N. Simon Tchekmedyian, MD • Nishan Tchekmedyian, MD • Kalust Ucar, MD • Lihong Wu, MD

Patient Name: _____ Account #: _____

DOB: _____ Age: _____ Gender: _____

Individual Patient’s Authorization Form

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

You give your authorization to use or disclose your protected health information as described in Section 2 below. You give this authorization voluntarily.

1. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information you are authorizing to be used and/or disclosed.

Name the people and/or organizations (or the kinds of people and/or organizations) that you **are authorizing** to use and/or to disclose the protected health information described above.

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

YOU HAVE A RIGHT TO HAVE A COPY



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Name the people and/or organizations (or the kinds of people and/or organizations) that you **are NOT authorizing** to receive and use your protected health information.

2. ENDING THIS AUTHORIZATION

Select by checking one of the following two choices:

This authorization will end on the following date: _____

This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below.

3. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

You understand that you may revoke this authorization at any time by giving written notice to the Privacy Offices at our office. However, you understand that you may not revoke this authorization for any actions taken before receipt of your written notice to revoke this authorization. In addition, you understand that if you are giving this authorization as a condition of obtaining insurance coverage and you revoke this authorization; the insurance company has a right to contest your claims under the insurance policy.

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4. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

You understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on your signing this authorization. However, you understand that signing an authorization that permits the use and/or disclosure of your protected health information for research purposes may be a condition of your treatment if you are undergoing research-related treatment. Under some circumstances, a health plan may condition your enrollment in a health plan or your eligibility for benefits on your providing an authorization permitting the health plan to make enrollment and eligibility determinations.

5. INDIVIDUAL PATIENT’S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form. I also understand that once information is disclosed to a third party, that party may in turn disclose it to someone else also who is not covered by laws protecting confidentiality.

Signature: _____

If this authorization form is signed by a personal representative for the individual patient: Personal Representative’s Name/Relationship (PRINT): _____

Signature: _____

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