Nissa Keyashian, M.D.
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Authorization for Release of Healthcare Information

I authorize Dr. Nissa Keyashian to release and receive my healthcare information to and from the following healthcare providers:

Number of Individual/Entities specified below: _____

Name_____ Phone Number_____

Please Specify Type of Provider_____

Name_____ Phone Number_____

Please Specify Type of Provider_____

Name_____ Phone Number_____

Please Specify Type of Provider_____

I understand that this healthcare information may include mental health, alcohol and/or drug treatment and will be used for the purposes of evaluation and treatment. I also understand that the authorization is completely voluntary and may be revoked at any time by submitting a written request to revoke the authorization to the office of Dr. Nissa Keyashian (address listed above). Treatment cannot be conditioned on completing an authorization.

This authorization will expire on _____ (or one year from date signed).

_____ _____
Signature of Patient Date

_____
Printed Name