Victory Physicians
Frank B. Arian, M.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________

Previous Name: ______________________________ Social Security Number: _______________

I request and authorize ____

to release healthcare information of the patient named above to Frank Arian, M.D. a California Professional Corporation dba Victory Physicians. This authorization expires on __________________________.

This request and authorization applies to:

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

  ____

- ☐ **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: ______________________

Please fax all medical records to (760) 327-1477 within 48 hours.

490 South Farrell Drive Suite C-104 • Palm Springs, California 92262-7962
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