Ravonkavi
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Authorization for Release of Information

_____

Full Patient Name (print) **Date of Birth**

I hereby authorize the release and exchange of information between

_____ **And** _____
_____ _____
_____ _____

Description of information to be disclosed:

_____

Statement of purpose/need for this information:

_____

Unless otherwise revoked, this authorization expires on _____. If no date is indicated, the authorization will expire 7 years after the date of signing this form. This authorization may be revoked at any time. The revocation must be in writing signed by you, or your patient representative, and delivered to 4199 Campus Drive, Suite 550; Irvine, CA 92612. The revocation will take effect when it is received You are entitled to receive a copy of this authorization. A copy of this form shall be as valid as the original.

_____
Signature of Patient/Legal Guardian

_____ _____
Printed Name and Relationship **Date**

Witness: _____ _____
Date