Rheumatologists in Orange County

☐ **Lalitha Ananth, M.D.**
11100 Warner Ave. #304
Fountain Valley, CA 92708-7512
(714) 549-4081

☐ **Anthony Bohan, M.D.**
320 Superior Ave. #340
Newport Beach, CA 92663
(949) 645-7172

☐ **Hernan Castro-Rueda, M.D.**
26732 Crown Valley Parkway
Mission Viejo, CA 92691

(949) 347-6044

☐ **Robin Dore, M.D.**
12791 Newport Ave. #201
Tustin, CA 92780
(714) 505-5500

☐ **Catherine Driver, M.D.**
26732 Crown Valley Parkway
Mission Viejo, CA 92691
(949) 347-6044

☐ **Robert Freed, M.D.**
16300 Sand Canyon Ave. #708
Irvine, CA 92618
(949) 753-1666

☐ **Sunil Gupta, D.O.**
MemorialCare Laguna Hills
26538 Moulton Parkway #38E
Laguna Hills, CA 92653
(877) 696-3622

☐ **Dawn Hnat, M.D.**
1401 Avocado Avenue
Newport Beach, CA 92660
(949) 721-6788

☐ **Noreen Hussaini, M.D.**
MemorialCare Costa Mesa
722 Baker St.
Costa Mesa, CA 92626
(877) 696-3622

☐ **Mark Jason, M.D.**
25411 Cabot Road
Laguna Hills, CA 92653-5517
(949) 364-5119

☐ **Behnam Khaleghi, M.D.**
705 West LaVeta Suite #109
Orange, CA 92868
(714) 689-2701

☐ **Kathy Karamlou, M.D.**
355 Placentia Ave. #208
Newport Beach, CA 92663
(949) 631-6500

☐ **Roger Kornu, M.D.**
12791 Newport Ave.
Tustin, CA 92780
(714) 406-4461

☐ **David Kovacs, M.D.**
26732 Crown Valley Parkway #151
Mission Viejo, CA 92691
(949) 347-6044

☐ **Lee Joo-Hyung, M.D.**
1140 W La Veta Ave #610
Orange, CA 92868
(714) 245-0492

☐ **Christine Leehealey, M.D.**
4950 Barranca Parkway #205B
Irvine, CA 92604
(949) 654-3763

☐ **Wesley Mizutani, M.D**.
19066 Magnolia St.
Huntington Beach, CA 92646
(714) 668-0068

☐ **Christine Park, M.D.**
31862 Coast Highway #305
Laguna Beach, CA 92651
(949) 499-1339

☐ **Andrew C. Phan, M.D.**
St. Joseph Heritage Medical Group
2501 East Chapman Ave.
Orange, CA 92869
(714) 628-3230

☐ **Jaya Philipose, M.D.**
26732 Crown Valley Parkway
Mission Viejo, CA 92691
(949) 347-6044

☐ **B. Burt Rahavi, M.D.**
400 Newport Center Drive #602A
Newport Beach, CA 92660
(949) 759-9110

☐ **Simranjit Singh, M.D.**
26732 Crown Valley Parkway
Mission Viejo, CA 92691
(949) 347-604

☐ **Other**
Name: ______________________________ Phone: ____________________
Address: ______________________________ Fax: ____________________
City/State/Zip: ______________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

I, ______________________________ *(print your name)* hereby authorize Alan R. Schenk M.D. and *Arthritis & Rheumatic Disease Center, Inc.* to release my medical information to ____ *(indicate name of physician)*. The following information is to be released:

☐ Entire medical record ☐ Other (please specify:

____

Please indicate your understanding of the following by inserting your initials in the spaces below:

_____ I understand that if applicable, the information in my medical record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health issues or treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless (please specify):

____

____.

_____ I understand my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ This authorization remains valid unless canceled in writing

_____ Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein.

RESTRICTIONS

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information.

_____ I release Alan R. Schenk MD and *Arthritis & Rheumatic Disease Center, Inc*. and its employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may inspect or obtain a copy of the health information I am being asked to allow the use or disclosure of. I may revoke this authorization and any time, but I must do so in writing and submitted to the following address:

Arthritis & Rheumatic Disease Center, Inc.
24331 El Toro Road #380
Laguna Woods, CA 92637

______________________________ ____________________

Signature Date