Authorization to Release Medical/Psychiatric Information

A. **Authorization parties:** I hereby authorize **Brian S. Taylor, M.D., Joyce Weckl, PMHNP, or Fernando Cervantes, PMHNP** to:

_____**disclose** information to: (and/or) _____**obtain** information from:

Name of individual or agency: _____
Address, city, state, zip code: _____
Phone and/or fax number: _____

B. **Content:** I understand that I have the right to limit the content of information to be released. I have indicated below the information which is authorized for release:

___All information **without exception**, including but not limited to information regarding AIDS/HIV, drug or alcohol abuse, personal and family history, diagnosis/assessment, test reports, nature and dates of treatment received, medication prescribed, and treatment plan.
___ All medical information and treatment dates, **except**: _____
___Only the following information: _____

C. **Forms:**

___Verbal exchange of information

___Send copy of Discharge Summary and Admission Psychiatric Evaluation to:

_____
Name of Specific Provider

D. **Duration:** This consent is effective immediately. I may revoke this consent in writing at any time, except for information already released.

E. **Explanation:** This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Records Act of 1981, Section 56, et seq. of the California Civil Code. I understand that I have a right to receive a copy of this authorization and that a copy of this form is as valid as the original. I understand that the recipient may not further disclose my medical information unless another authorization is obtained from me or such disclosure is specifically required and permitted by law.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

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