Request And Authorization to Release Confidential Information

I, the undersigned, hereby request the release of confidential information and grant authorization for the release of confidential information regarding the following patient, including personal, mental health, chemical dependency, or medical history, findings, opinions, diagnoses, services rendered, and prognoses, __ except for _____.
__ with no exceptions.

Patient's Name	Date of Birth	Social Security Number	Approximate Date(s) of Treatment

__ Released by
__ Furnished to
__ Both

James J. De Santis, Ph.D.
Clinical Psychology
138 North Brand Boulevard, Suite 300
Glendale, CA 91203-4618
(818) 551-1714 Voicemail

__ Released by
__ Furnished to
__ Both

_____

_____

_____

Information requested is the following:

__ Pertinent summary
__ Medical history & exam results
__ Psychiatric evaluation results
__ Psychological test results
__ Complete patient record
__ Psychosocial history
__ Consultation reports
__ Diagnostic impressions
__ Course of treatment
__ Progress/process notes
__ Discharge summary
__ Dates of service
__ School or work performance
__ Other (specify): _____

This information is for the purpose of:

__ Evaluation
__ Treatment Planning
__ Forensic Service
__ Continuity of care
__ Consultation
__ Doctor's Lien
__ Referral
__ Insurance reimbursement
__ Subpoena
__ Other (specify): _____

This authorization shall be effective immediately. A photocopy of this authorization shall be considered as valid as the original. Information may be released orally, in writing, or by photocopy. Information disclosure may be in person, by telephone, mail, or facsimile.

I understand that I have no obligation to consent to release of information, that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, in which event information cannot and will not be released, unless otherwise required by law.

I understand the recipients of information are prohibited by law from making any further disclosure to third parties unless expressly permitted by additional written consent or otherwise required by law.

I understand that I can revoke my consent in writing at any time in writing, except to the extent that action has already been taken in reliance upon my consent. If not earlier expressly revoked, this authorization will remain in effect until six months after service is terminated.

I agree to hold harmless those authorized above, and their agents, designees, and representatives from any and all liability arising from the release of information to the person(s)/agency(ies) designated above, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

I understand that I have a right to receive a copy of this authorization upon my request. A copy of this form has been requested and received: __ Yes __ No

I, the undersigned, am: __ the above-named patient, __ the parent or legal representative of the above-named minor patient, __ the beneficiary or personal representative of the above-named patient who is deceased.

I have read, understood, and agreed to the above conditions. I have clarified any questions before signing. I hereby grant my consent.

Patient, Parent, or Responsible Person Signature	Printed Name	Relationship, if other than patient	Date