Remedy Psychiatry
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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56.104 et seq.

I hereby authorize Remedy Psychiatry, Inc.. to to disclose written and oral information which pertains to my assessment and/or treatment, and to receive information from the below individual or medical office, for the purpose of my care:

Name of therapist/Doctor's office/family member that patient is giving permission to receive/disclose information to/from Remedy Psychiatry:_____

Contact Number: _____Email address:_____

This may include any and all records including medical and psychiatric information, laboratory reports, imaging, drug and alcohol history, of the patient as specified below, for the treatment period of today up to ten years from this day, or if preferred, the date of: ____/____/_____.

My signature below acknowledges my understanding, authorization, and consent for the following:

1. This RELEASE OF PATIENT INFORMATION AUTHORIZATION is valid for ten years if not revoked earlier.
2. This authorization covers both the release of that information specified above presently compiled and information to be compiled during the course of the patient's hospitalization or outpatient treatment.
3. Use of this authorization form may reveal or imply that mental health services have been/are being provided to the patient.
4. This authorization is subject to my revocation at any time except for information already released.
5. I understand that I have a right to receive a copy of this authorization.
6. A copy of this authorization is as valid as the original.
7. I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained for me, or unless such use or disclosure is specifically required or permitted by law.
8. I have the right to refuse this authorization by not signing below.

_____ Date of Birth: _____
(Print name of patient)

_____ Date: _____
(Signature of patient)