Authorization to Release Medical/Psychiatric Information

Patient Name/Previous Name______________________________ **DOB**____________________

A**uthorization Parties**: I hereby authorize Brian S. Taylor, MD or Joyce Weckl, PMHNP to obtain or disclose information to/from:

Name of Individual or Agency: ____
Address, City, State, Zip Code: ____
Phone and/or Fax: ____

Information to be Released:

- ☐ All information without exception, including but not limited to: HIV results, substance abuse treatment, family history, psychological testing, therapy notes, treatment plan, diagnosis, test reports, medications.
- ☐ Admission and Discharge Summary Complete with Labs
- ☐ Lab results, all or specific dates:_______________________________________
- ☐ Only the following information: ____

Purpose of Disclosure:

- ☐ Continuity of Care
- ☐ Other: ____

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

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 use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required and permitted by law.

Conditions: I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment.

_________________________________ Print Name ____________________ ____________
Signature of Patient Date

_________________________________ Print Name ____________________ ____________
Signature of Parent/Legal Guardian/ Conservator Date

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