Authorization for Release of Medical and Mental Health Information

The Clinic

_____ _____ hereby authorizes:
Patient Name Date of Birth

The Clinic
912 Cole St. #368
San Francisco, CA 94117
p 415-843-1523 f 415-484-7083

to release/exchange medical/mental health information to/with:

❑ Primary Care Provider
Name _____ E-mail _____
Last Seen (Month/Year) _____ Phone _____ Fax _____

❑ Psychiatrist
Name _____ E-mail _____
Last Seen (Month/Year) _____ Phone _____ Fax _____

❑ Therapist
Name _____ E-mail _____
Last Seen (Month/Year) _____ Phone _____ Fax _____

❑ _____ Relationship
Name _____ E-mail _____
Phone _____ Fax _____

❑ _____ Relationship
Name _____ E-mail _____
Phone _____ Fax _____

Type of disclosure: ❑ Verbal ❑ Copies of Records ❑ Letter ❑ Proof of Attendance

Specify the information you authorize to be released:
- ❑ Mental health information *(Lanterman-Petris-Short Act, WIC §5000 et seq.)*
- ❑ Medical information *(May include drug/alcohol and mental health information documented by a primary care practitioner)*
- ❑ Drug and alcohol abuse diagnosis or treatment information *(42 C.F.R. §§2.34 and 2.35)*
- ❑ HIV/AIDS test results *(Health and Safety Code §120980(g)*
- ❑ Scheduling Information
- ❑ Claims/Billing Information

For the purpose of:
- ❑ Further mental health evaluation, treatment, or care
- ❑ Rehabilitation program development or services
- ❑ Treatment Planning
- ❑ Client safety/welfare check
- ❑ Coordination of Care
- ❑ Billing Support

Unless otherwise revoked, this Authorization will expire 12 months after the date of my signing this form.

_____ _____
Signature of Patient (or person acting for patient) Date

Notice: *Your healthcare professional is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.*

Your Rights: *This Authorization to release health information is voluntary. This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your client/patient representative, and delivered to your healthcare professional. You are entitled to receive a copy of this Authorization.*