PSYCHOLOGICAL AND PSYCHIATRIC SERVICES
aspen
10737 Laurel Street #230
Rancho Cucamonga, CA 91730
Fax:909-989-5556

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider named below to release confidential PSYCHIATRIC AND MENTAL HEALTH information and records. Note: Information and records regarding HIV, alcohol/substance abuse, and genetic information have special rules that require specific authorization.

Authorization
I hereby authorize Dr. Denise Persichino, D.O.

To release/ obtain information of :

_____ (Patient's Name)

_____ (Patient's DOB) regarding my psychiatric and mental health illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including X-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To/From:
Name: _____
Address: _____
_____
Phone: _____ Fax: _____
The medical information /records will be used for the following purpose:
____ Continuity of care
____ Other:_____

This authorization is:
_____ Limited to the following medical information:

_____
_____

_____
_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance abuse _____(initial)
Tests for antibodies to HIV _____(initial)
HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____

Signature of patient or legal/personal Date

_____

Patient's Name (PRINT) Date

_____

Patient's Date of Birth