10737 Laurel Street #230
Rancho Cucamonga, Ca 91730
Fax: 909 989 5556

PSYCHOLOGICAL AND PSYCHIATRIC SERVICES
aspen

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) 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: Mark Welch, DO / Theresa Anderson, N.P/Chrystanya Adeniji, N.P /Devon Canfield, N.P (Physician/Healthcare Facility)

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:_____

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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*

_____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth