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AUTHORIZATION FOR OBTAINING AND RELEASING CONFIDENTIAL INFORMATION

I, _____ of _____
(Name) (Address)

(City, State) (Zip code)

Date of Birth: _____ Social Security Number: _____

Authorize:

- To Obtain
 To Release

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Verbal Exchange | <input checked="" type="checkbox"/> Discharge Summary | <input checked="" type="checkbox"/> Interdisciplinary Assessments |
| <input checked="" type="checkbox"/> Radiology Results | <input checked="" type="checkbox"/> Progress Notes | <input checked="" type="checkbox"/> Physician Orders |
| <input checked="" type="checkbox"/> Admission Evaluation | <input checked="" type="checkbox"/> Psychiatric Evaluation | <input checked="" type="checkbox"/> History and Physical |
| <input checked="" type="checkbox"/> Psychological Testing | <input checked="" type="checkbox"/> HIV Testing | <input checked="" type="checkbox"/> Laboratory Results |
| <input checked="" type="checkbox"/> Treatment Plan(s) | <input checked="" type="checkbox"/> Medication Records | <input checked="" type="checkbox"/> Treatment Summary |
| <input type="checkbox"/> Other _____ | | |

To / From: _____

Address _____

Telephone: _____ Fax: _____

I hereby authorize Dr. Pera to release / obtain copies of Psychiatric, Drug and Alcohol, HIV, and Medical information from the health care record pertaining to hospitalization / treatment for All Dates (specify dates or treatment) by mail, courier, telephone conversation, electronic mail, or facsimile transmittal to or from .

These records are required for the purpose of: (check at least one)

- Providing information to health care providers Legal Purposes Social Security / Disability
 Other: (specify) _____

Please initial the following:

- _____ I understand that my healthcare and payment for health care will not be affected if I do not sign this form, and I am entitled to a copy of this form (upon request) after I sign it.
_____ I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that this authorization expires exactly three years from the date of my signature below.
_____ I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written and dated communication to the Medical Records Department at the office of Dr. Pera

This information has been disclosed from confidential records protected by state and federal laws; those that are more stringent will apply. Any further disclosure of this information is not permitted without specific authorization to do so.

I certify that I have read and fully understand the content of this page.

Signature of Patient: _____ Date: _____

Signature of Parent / Guardian _____ Date: _____