Early Interventions

Child, Adolescent and Family Psychiatry

Authorization to Obtain and Release Information

Patient's Name: _____ DOB: _____

I authorize my physician *Amanda J. Cervantes, M.D.* to exchange information with:

Individual or Organization: _____

Address: _____ Phone Number: _____

_____ Fax Number: _____

_____

Please release the following information from _____ to _____
(date) (date)

I acknowledge the information to be released may include material related to substance abuse, mental health, and/or HIV/AIDS.

[ ] Complete Medical Record
[ ] Psychiatric Diagnostic Evaluation
[ ] Psychological Evaluation
[ ] Consultation Report
[ ] Verbal Communication
[ ] Social History
[ ] Other _____

[ ] Specific information as needed
[ ] History and Physical
[ ] Physician or Counselor's Discharge Summary
[ ] X-ray
[ ] EKG
[ ] Lab _____

The purpose of disclosure: [ ] Psychiatric Evaluation [ ] _____

This statement can be revoked at any time before disclosure of the information, and expires, in any event, one year after it is signed. A photocopy of this authorization shall be valid as the original. Information disclosed is protected by Federal confidentiality rules. **Federal rules prohibit further disclosure of this information until further disclosure is expressly permitted by the person whom it pertains to.** Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date: _____

Signed: _____ Signed: _____
patient Parent or Legal Guardian

Photocopies of Records released on _____, by _____
Date Employee

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