Inland Pacific Psychological Services

Authorization for Disclosure of Medical Information

Treatment, payment, enrollment or eligibility benefits will not be conditioned on my providingor refusing to provide this authorization. I hereby authorize

____

(Name of Clinician/Doctor/Hospital sending records)
to release records/information as indicated below regarding:

Patient Name: ______________________________ DOB: ____________________

Address: ______________________________ Tel: ____________________

Release information to: ______________________________________

Name of Receiving Party

____

Address

____________________ ____________________

Telephone # Fax #

DURATION: This authorization shall become effective immediately and shall remain in effect until____________________(enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization is also subject to written revocation by theundersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or othershave acted in reliance upon this authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from meor unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box to indicate the type of information to be disclosed:

- ☐ Health Information Record
- ☐ Drug/Alcohol Record
- ☐ Mental Health Record
- ☐ HIV Test Results
- ☐ Other (Specify) ______________________________

I request that the health information released pursuant to this authorization be used for the following purposes only:

____

______________________________ ____________________

Signature of Patient or Patient's Representative Date

____

Indicate Relationship (if signed by other than Patient)

I have received a copy of this authorization: ____________________(Initial)
A Copy of this authorization is valid as an original.