



So Cal Psychiatric Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to release

- a. All psychiatric records
- b. Letter to _____ dated _____
- c. Verbal
- d. Other

To
Recipient's Name _____

Address _____

Phone Number _____ Recipient's relationship to patient _____

Regarding _____ Purpose of release _____

This authorization for use or disclosure of medical information, is being authorized by me giving SCPC permission to disclose mental health/psychiatric records and information obtained in the course of the diagnosis and/or treatment of my child or me. I understand that the information disclosed pursuant to this authorization might be re-disclosed by recipient and may no longer be protected by the Federal Privacy Regulation 145 CFR Part 1641. This disclosure of medical/psychiatric information complies with the terms of the Confidentiality of Medical Information Act 1981, section 56, et Seq. California Civil Code.

I authorize I do not authorize

to release or disclose information or records relating to the diagnosis, treatment or other therapy for the conditions of drug use, alcoholism or alcohol use, infection with the human immunodeficiency virus (HIV), psychotherapy, educational, psychological and laboratory test results, and genetic/familial information.

If my consent to this information is limited, the limitation is written here:

I may revoke this authorization at any time, in writing, except to the extent action has been taken in reliance upon this consent.

Date _____

Signed _____