PsyCare, Inc.

A professional medical corporation
A comprehensive behavioral healthcare system
HEADQUARTERS: 4550 Kearny Villa Road, Suite 116, San Diego, CA 92123
Phone: (858) 279-1223 Release Fax: (858) 467-7161

Authorization to Release Information

I hereby authorize ____

to release – All psychiatric/psychotherapy records (One Time Only On-going up to one year __________) Initials

Letter to: ________________________________ dated:____________________

Verbal

Treatment Summary

Other __________________________ (One Time Only On-going up to one year_____) Initial Here

To: Recipient's name, address & phone #'s:____

____

Phone number:___________________ Fax number: _______________________

Recipient's relationship to the Patient/Client:____

(If legal counsel, indicate: – PsyCare Patient's attorney or – Opposing Attorney)

Regarding: ____D.O.B: _______________

(Patient/Client's Name) (Patient/Client's Date of Birth)

Purpose of release: (**mandatory**)____

This authorization for use or disclosure of medical information is being authorized by me giving PsyCare, Inc. 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 the recipient and may be no longer protected by the Federal Privacy Regulation [45 CFR Part 164]. This disclosure of medical/psychiatric information complies with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et. Seq, California Civil Code.

 I AUTHORIZE: To release or disclose any information or records relating to the diagnosis, treatment or other therapy for the conditions of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia, 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 to the Administration department, except to the extent action has been taken in reliance upon this consent. If it is not earlier revoked, this consent shall terminate without express revocation one year from date shown below.

______________________ Signed: ____

(Date) (Patient/Client's Signature)

OFFICE USE ONLY (Must be completed before submitting request to Admin):
- **MD'S ONLY-** ***Consent to release***: _______________
- **Therapist's initials (*Pt seen individually*)**:__________
- **Fee collected? (*Initials/ type of payment*)**:___________
- **SEND FROM OFFICE** – **SENT FROM ADMIN.**

Account #___________________ Office:________
Staff Initials:__________

____
(If signed by other than Patient/Client, please indicate relationship)

____
(Signature of Minor-ages 12-17; If unable/unwilling to sign list reason)

ADMINISTRATION BOX:
- **Ok to Release Forms/ Letter / Paperwork** (***circle one***)
- **OK to Release Records**
- **OK communicate Verbally only** ________________ ______

Administrative Signature Date