Dr. Amy Goldman

AUTHORIZATION TO USE OR RELEASE PROTECTED HEALTH INFORMATION REGARDING MECIAL, PSYCHIATRIC AND SUBSTANCE ABUSE RECORDS

I herby authorize:

To receive, use or release health information and records obtained during the course of treatment of:

Patient Name: ____Date of Birth:_______________

Address:____

Social Security Number:____

The information is to be used or disclosed to/from the following person or organization:

Person/Organization Name:____

Address:____

Phone:______________________________________Fax:_____________________________________

Specific records may include all dates of service and all or any part of records unless indicated below:

____

The purpose of the information release is as follows:

____

I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date this authorization is signed. ______(Please initial)

I understand that I may refuse to sign this authorization and that my signing is voluntary. I herby release Dr. Amy Goldman from any liability arising from this authorization. ______(Please initial)

I authorize the parties listed above to talk by telephone if relevant to the above listed purpose for this release of records. ______(Please initial)

I can make a written request to stop use or release of information at any time, although I understand that I cannot stop information previously used/disclosed under this authorization. ______(Please initial)

I understand that minors over 12 years old must sign along with parents/guardians. ______(Please initial)

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statues, Rules and Regulations including California Confidentiality of Medical Information Act: California Administrative Code, Title 22; California Welfare and Institutions Code 5328; Title 42 of the Code of Federal Regulations; and HIPPA.

____ _____________________________

Patient Signature Date

____ ____________ _________________

Parent or Legally Authorized Representative Date Relationship to Patient

____ _____________________________

Witness Signature and Printed Name Date