U Are Well

591 Camino De La Reina, Suite 918, San Diego, CA 92108
Phone: 858 414-0411

Authorization to Release Information

I hereby authorize _____

to release All psychiatric/psychotherapy records (one Time Only) On-going up to one year (_____)Initial Here

Letter to:_____ dated: _____

Verbal

Treatment Summary

Othcr _____ (__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: __U Are Well 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 U Are Well 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 mav 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 mav revoke this authorization at anytime,in writing, 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)

_____
(If signed by other than Patient/Client, pleicse indicate relationship)

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

OFFICE USE ONLY

Therapist's initials *(Pt seen individually):* _____
Fee **collected? (Initials/type of payment**

_____
SEND FROM OFFICE **SENT FROM ADMIN.**

Account If_____ **Office:**_____
Staff **Initials:** _____

ADMINISTRATION **BOX:**
__Ok to Release **Forms/ Letter** f Paperwork (circ/e one)
__OK to Release Records
__OK communicate Verbally onlv _____ _____
Administrative Signature Dale