HEAL PSYCHIATRIC SERVICES INC.

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SAN MATEO, CA 94402
PHONE: 650-273-4082. FAX: 650-275-7559
WEBSITE: www.healpsych.com

This authorization is valid for one year from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____
Patients Name

_____
Patients Signature

_____ Date:----------
Guardian's Signature (if patient is a minor)

Patient Name:		**DOB:**	**Initial each specific consent to release**
Family Members or Significant Others	Name/Relationship Name/Relationship Name/Relationship	**Purpose:** • To facilitate understanding and support in treatment. • To aid in diagnosis and continuity of care. **Type of information to be disclosed:** • All medical records ☐ • Progress Notes ☐ • Labs ☐ • Medications ☐ • Evaluations ☐ • Other: _____ Text _____	☐ Yes ☐ No _____ Initial
Mental Health Professionals	Psychiatrist Phone Therapist Phone		☐ Yes ☐ No _____ Initial
Primary Care Physician	Name/ Group Phone		☐ Yes ☐ No _____ Initial
Pharmacy			☐ Yes ☐ No _____ Initial
Other Specialists	Name/ Group/ Phone Name/ Group/ Phone Name/ Group/ Phone		☐ Yes ☐ No _____ Initial
Referrals			☐ Yes ☐ No _____ Initial