EB Psych Solution, Inc.
1125 E 17th St, Suite N354 | Santa, Ana, CA 92701
Ph: (714) 834-9458
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AUTHORIZATION FOR RELEASE OF INFORMATION / MEDICAL RECORDS

NAME: _____ DATE OF BIRTH: _____

RELEASE TO: _____
(Physician Name / Group Name / Address)

PHONE NUMBER: _____ FAX NUMBER / E-mail: _____
(Physician Name / Group Name) **(Physician Name / Group Name)**

This authorization is for the use or disclosure of psychiatric / medical information, including diagnosis and treatment of mental disorders.

I hereby authorize the following person/agency to furnish the above name and recipient with the records and information listed below:

_____

I understand that I may revoke this authorization at any time, except to the extent that the person/agency has already acted in the reliance on it. I understand that the recipient may not further use or disclose this information uncles another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

____ NO _____ **____ YES _____**
(Initial) **(Initial)**

Information Requested:

___ Psychiatric Evaluation **___ Discharge Summary**
___ Progress Notes **___ Other (_____)**

Patient / Guardian Signature: _____ Date: ___/___/___

Authorized Representative: _____ Date: ___/___/___