

Fax to Amy (Office Manager) at : 805.919.5261 and please allow up to 2 weeks for processing.

Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

I authorize Dr. Neal Mazer to release information to:

AND/OR

I authorize Dr. Neal Mazer to obtain information from:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone #/Fax # (Include area code)

Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) Healthcare Insurance Coverage Personal Other

TYPE OF RECORDS AUTHORIZED: Psychiatric/Psychological Evaluation and/or Treatment
 Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

- Assessments Progress Notes Laboratory Test Results: _____
 Diagnostic Impression Discharge Summary Treatment Plans
 Treatment Summary
 Other: (please describe) _____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**
 When the requested information has been sent/received.
 90 days from this date. Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:
 When I am no longer receiving services from Dr. Neal Mazer.
 One year from this date. Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Dr. Neal Mazer, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient): Parent Legal Guardian Other: _____

Patient or Representative has been provided a copy of this authorization: _____

Dr. Neal Mazer