**Psychiatric Care for Seniors**

**3000 Citrus Circle, Suite 107**

**Walnut Creek, CA 94598**

**Phone: (925) 364-0082**

**Fax: (866) 284-3572**

**Authorization for Use or Disclosure of Health Information:**

**Patient Information:**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Recipient Information:**

I hereby authorize K.Singh, MD/Psychiatric Care for Seniors to:

\_\_Disclose to

\_\_Request from

Clinician/Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be release:**

\_\_My entire mental/Medical record.

\_\_Only the following information (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Purpose of Health Information Release:** \_\_Evaluation/treatment planning\_\_ Care coordination

\_\_Billing/payment\_\_ Others (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Patient/Guardian/Conservator/Relationship to Patient Date

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.