Psychiatric Care for Seniors
3011 Citrus Circle, Suite 101
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:_____

_____

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):_____

_____

Purpose of Health Information Release: __Evaluation/treatment planning__ Care coordination

__Billing/payment__ Others (specify)_____

_____+_____ _____

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

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.