SAN MARINO PSYCHIATRIC ASSOCIATES, A MEDICAL GROUP
2400 Mission Street, San Marino, CA 91108 (626) 403-8999

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:________________________________ Patient Birthdate:____________________

I, ____________________________________, hereby authorized **San Marino Psychiatric Associates, A Medical Group, (SMPA)** to disclose the specific information and or/records identified below:
(Print Name)

- ☐ Psychosocial Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Medical Management Information
- ☐ Presence/Participation in Treatment
- ☐ Progress Notes
- ☐ Toxicological Reports/Drug Screens
- ☐ Discharge/Transfer Summary
- ☐ Demographic Information
- ☐ Other ______________________________

The information identified above is to be released to:____________________________________
(Name of person/facility to receive records)

____
(include address of person/facility to receive records)

The purpose of this disclosure of information is required for the purpose of coordination of care.
If other purpose, please specify: ____

This authorization will become effective immediately. If not revoked earlier, it will remain in effect for one year from date signed or as otherwise indicated:________________. It may be revoked at any time by written notification to SMPA.

I understand that certain State and Federal Regulations protect the confidentiality of the information in these records. These regulations also require that I voluntarily and knowingly sign this document before SMPA can release any records, and that I may refuse to sign my signature in which event the records cannot and will not be released by SMPA. I understand that I may receive a copy of this authorization.

____
Signature of Patient Social Security Number Date Signed

____
Signature of Parent, Guardian or Personal Representative Date Signed

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

____
Signature of Staff Witness Date Signed

<u>REDISCLOUSRE</u>: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part .2