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 authorize _____
(Print Name) (Name of person/facility to release information)

_____
(include address of person/facility to release information)

to release the information specified below to **San Marino Psychiatric Associates, A Medical Group** (SMPA). The purpose of this disclosure is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:

_____

Description of Information being requested:

- ☐ Psychosocial/Psychiatric Evaluation
- ☐ Psychological and/or Educational testing
- ☐ Treatment Plan or Summary
- ☐ Discharge/Transfer Summary
- ☐ Presence/Participation in Treatment
- ☐ Medical Management Information
- ☐ Other_____
- ☐ Report of all lab results (last 6 months)
- ☐ Toxicological Reports/Drug Screens
- ☐ Reports of medical treatment (last 6 months)
- ☐ Report of most recent physical examination
- ☐ School records including academic performance and result of most recent testing
- ☐ Other_____

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:_____.

I am fully aware that certain State and Federal Regulation protect the confidentiality of the information in these records. These regulations also require that I voluntarily and knowingly sign this document before the Named Facility can release any records, and that I may refuse to sign my signature in which event the records cannot and will not be release by the Named Facility to 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

REDISCLOSURE: 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