Southern California Psychiatric Group, Inc

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CONSENT TO RELEASE PROTECTED HEALTH / MENTAL HEALTH / ALCOHOL AND DRUG / HIV TREATMENT RECORDS

Must review carefully and check the boxes that apply for this form to be valid for the intended purpose

I hear by consent / authorize YOUR DOCOTR'S NAME HERE _____ at SCPG, Inc to

❑ **Obtain** / ❑ **Send** my treatment records from / to / ❑ _____

_____
External Doctor / Facility Name

_____
External Doctor / Facility Mailing Address (Include City, State, Zip Code)

Ph _____ Fax _____ Email _____

Date(s) of Treatment: ❑ Last Visit / ❑ From _____ To _____ / ❑ All

For ❑ Continued Care / ❑ Patient Access / ❑ Make records available for review BY appointment /

❑ Other _____

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify expiration date, event or condition, this authorization will expire in twelve months from the date of signature below.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in HIPPA. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I questions about disclosure of my health information, I can contact the Medical Records Department.

Patient Name: _____, _____ ____ Date of Birth: _____
(PLEASE PRINT) Last First M.I.

SSN: _____ Phone: (_____) _____-_____

Address _____

_____ _____ _____
Signature of Patient or Legal Representative Date Relationship to Patient

Name Signed: _____