Inland Psychiatric Medical Group Inc.
Ph (909) 335-3026
1809 W. Redlands Blvd
Redlands, CA 92373

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

[ ] All of my health information that the provider has in his or her possession including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, HIV/AIDS status, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence.

[ ] All of my health information described above except for the following:

____

[ ] Only the following records: Insert dates of treatment, types of treatment)

____

Check box that applies: Release my records to Obtain my records from Access of Care

Authorization for Release or Access of Care

_________________________________ _________________
Individual/Agency Name Phone Number

_________________________________ _________________
Address Fax Number

____
City State Zip

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Term: This authorization will remain in effect until the provider/office receives written consent to revoke the release.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Revocation: I understand that the Authorization will remain in effect until I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

Patient Name:____ Date of Birth: ______________
First Middle Last

_________________________________ _________________ ____________
Signature of Patient or Legal representative Legal Relationship Date