Roula Creighton, MD DFAPA

A diplomate of the American Board of Psychiatry and Neurology, Inc.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ DOB: _____

I request and authorize: Name: _____
Address: _____
Phone:_____Fax: _____

to release and/or receive mental health information to/from: **Roula Creighton, MD**
4199 Campus Dr, Suite 550. Irvine, CA 92612
Phone: (949)271-9533 *Fax*: (949) 437-3428

Information to be Released: I specifically authorize the release of all health information including; information relating to medical history, mental or physical condition and any treatment received by me. This includes x-ray, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other providers that the above named health care provider may hold.

My Rights:

- I understand this authorization is voluntary.
- I may revoke this authorization at any time, provided that I do so in writing.
- I am entitled to receive a copy of this authorization.

Expiration of Authorization:
Unless otherwise revoked, this authorization expired on _____. If no date is indicated, this authorization will expire 12 months after the date this form is signed.

Right to Revoke: I understand that I may revoke this authorization at any time and for any reason by providing a written notice to my healthcare provider at the above office address. The revocation will be in effect immediately

Signature: _____ Date: _____