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Newport Beach, CA. 92660
Ph. (949) 642-7757
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AUTHORIZATION FOR RELEASE OF INFORMATION

Medical, Psychiatric and Substance Abuse Records

Patient Name
(first)_____(Middle)_____(Last)_____

Date of Birth_____SS#_____

Address_____

City/State/Zip_____Phone _____

[ ] Please **RELEASE** my medical information **TO**: [ ] **OBTAIN** my medical information **FROM**

Name of Individual/Organization _____

Address:_____

_____

Relationship to Patient_____Phone #_____Fax #_____

Email Address_____

Rights & Restrictions: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of this authorization to be used and/or disclosed under this authorization in accordance with my organizational policy. Photocopy/Fax may be used as original. I understand I have the right to revoke this authorization in writing at any time or change what information is to be released. My revocation will be effective upon receipt but will not be effective to the extent that this organization has taken action in release upon this authorization.

Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code # 56.10(x) may not further disclose the medical information except in accordance with a new authorization or as specifically required or permitted by law.

I,_____(name of patient/or guardian), hereby authorize **HMA, Inc**. to disclose information and records obtained in the course of my diagnosis and treatment, and to receive nformation about My diagnosis and treatment for the following purpose: to obtain previous medical/psychiatric history, assist in diagnosis and treatment and to coordinate care on an ongoing basis with my other providers.

_____

Patient/Guardian Signature *Date*