Grace Kwon D.O.
Psychiatrist

CONSENT & AUTHORIZATION TO USE, RECEIVE AND DISCLOSE MENTAL HEALTH INFORMATION

I, _____, hereby authorize _____

Patient to receive information about my diagnosis and treatment for the following purpose: to increase understanding of my previous history, diagnosis, and treatment; to coordinate care on an ongoing basis with other providers that are also treating me; or to discuss my care with friends or family that may provide support.

Information is to be disclosed to:

Name of individual/organization Phone Number Address

_____

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by South Coast Psychiatry to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation. I understand that I have the right to refuse consent and signing of this authorization and South Coast Psychiatry shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information. This authorization is effective immediately and remains in effect for 1year unless explicitly revoked in writing

PATIENT INFORMATION Today's Date:_____ Patient Name: _____/_____/_____ /_____ First MI Last Name you like to be called Patient Address: _____ _____ _____ _____ Street City State Zip Phone: Home_____ Cell: _____ Work: _____ E-mail address: _____ How may we contact you: Home ___ Cell___ Work___ Email___ (Check all that apply or 'P' for preferred method) Birth date: _____ Age: _____ Gender: Male ___ Female ___ SS # _____-_____-_____ Ethnicity: Caucasian ____ African-American ____ Asian ____ Hispanic ____ Other _____ Relationship Status: Single ___ Married ____yrs Serious relationship _____yrs Divorced _____yrs Children? Yes, ages _____ No _____

Grace Kwon D.O.
Psychiatrist

Print Name: _____

Signature: _____

Date:_____

THE HEALTHY MIND CENTER