South Coast PSYCHIATRY
Psychotherapy & Medication Management

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

I, _____, hereby authorize **South Coast Psychiatry**

(Name, Date of Birth)

to disclose information and records obtained in the course of my diagnosis and treatment, and 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 to be disclosed to:

Name of individual/organization	Phone Number	Address

I also consent to the specific release of the following records:

Drug/alcohol/Substance Abuse _____ (Initial) Tests for Antibodies to HIV _____(Initial)
Psychiatric/Mental Health _____ (Initial) HIV Diagnosis/Treatment _____(Initial)

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-disclose by the recipient and may no longer be protected by the HIPPA Privacy Rule, although applicable state laws may protect such information.

This authorization is effective immediately and remains in effect for 1 year unless explicitly revoked in writing.

Signature: _____ Date: _____
(Parent or Legal Representative)

If Legal Representative: Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____
(Name of Psychiatrist)