Advanced Psychiatry Associates
Hisham Soliman, MD, MPH

AUTHORIZATION OF THE RELEASE & EXCHANGE OF HEALTH INFORMATION

Name: _____ **Date of Birth:** _____

Phone: _____

Who has the information that you would like released?	**ADVANCED PSYCHIATRY ASSOCIATES**
To whom should the information be released?	**Relationship to patient:** _____ **Name:** _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

- ☐ **Mental Health Information (Lantern-Petris-Short act, WIC §5000 et seq.)**
- ☐ **Medical (including drug/alcohol and mental health information documented by a primary care practitioner)**
- ☐ **Drug and Alcohol abuse, diagnosis or treatment information (42 C.F.R. §§2.3.4 and 2.35)**
- ☐ **HIV/ AIDS Test Results (Health and safety code §120980(g))**
- ☐ **Generic/Genetic Testing Information (Health and safety code §120980(g))**

Type of information to be shared; (Scheduling, medications, treatment plan, etc.) Please be specific:

_____

Limitations upon this disclosure: _____

Date(s) of treatment, if applicable: _____

Purpose of this release is: ☐ **To Keep Medical Record Current** ☐ **Other:** _____

- ☐ **At the request of the patient/ patient representative**
- ☐ **Other (state reason):** _____

Unless otherwise revoked this authorization expires on: _____

_____ _____ _____(AM) (PM)

Signature (Patient, Parent, Guardian) **Date** **Time**

_____ _____ _____

Print Name **Relation to Patient** **Witness (only if patient unable to sign) or interpreter**