Authorization to Release or Exchange Confidential Information

			Phone:
By Signing This Consent, You Are A	Agreeing to An 1	Exchange of Information	on Between the Parties Below:
Who Has the Information?			
Previous Psychiatrist's Name:			
Address:			
Phone:	Fax:		_
Hospital Name:			
Address:			
Phone:	Fax:		<u> </u>
	1 1/ 1	10	
To whom should the information be a		0	
Hisham Soliman, MD, MPH / Folsom		ociates	
510 Plaza Drive, Ste 170, Folsom, CA			
Phone: 916-351-9400 Fax: 916-351-	-9449		
Information type(s) to be released/e	ychanged•		
 Mental Health Information (La 	_	art Act MIC 85000 at sa	a l
•		<u>-</u>	• •
			nented by a primary care practition
 Drug and Alcohol Abuse, Diag 			R. § §2.3.4 and 2.3 5)
 HIV/AIDS Test Results (Health 	and Safety Code	e §120980(g))	
 Generic Testing Information (Health and Safet	ty Code §120980(g))	
Type(s) of Information, if not specif			
Limitation upon this disclosure:			
Purpose of this release is:			
At the request of the patient/patien			
At the request of the patient patient patient of the Other (state reason):	ni representative		
Unless otherwise revoked, this authori	ization avniras		
Offiess otherwise revoked, this authori	ization expires _		(indicate date of event).
If no date indicated, the authorization	will expire 24 m	onths after the date of m	y signing this form
			(AM) (PM)
Signature (Patient, Parent, Guardian)	Date	Time	
Print Name Relation	on to Patient	Witness only if paties	nt unable to sign or Interpreter