Miriam Schultz, M.D.
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Telephone 415-787-3611

RELEASE OF INFORMATION

PRINTED NAME:_____

DATE: _____ DOB: _____

I authorize Miriam Schultz, M.D. whose office is located at the address above, to disclose and/or obtain from the following physician, psychiatrist, hospital, other treatment provider or organization, relative, friend, or any other person I choose to name below:

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

By signing below I acknowledge that the following information may be released, discussed, or disclosed. If you agree to the release of all protected health information (PHI), then check the first option. If you want to limit what is released, then choose the option you agree to and check that option.

__ Complete Medical/Psychiatric Record (FULL)
OR
__ Discharge Summary
__ Medication Records
__ Mental Health Diagnosis
__ Progress Notes
__ Substance Abuse Information (including assessment & treatment records)
__ Treatment Plan

I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to the office of Miriam Schultz, M.D. Unless otherwise revoked, this consent expires in twelve months from this date. I understand that once information is disclosed per my authorization, the information may be re-disclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

SIGNATURE: _____ DATE: _____