Dr Rochelle Calvert

PSY CA 22284

PSY NM 1639

AUTHORIZATION TO RELEASE AND/0R OBTAIN HEALTHCARE INFORMATION

Patient Information

_____ Name

_____ Street Address

(_____) _____ Phone Number

_____ City and Zip Code

_____ / _____ / _____ Date of Birth

Please Indicate How You Would Like Your Health Information Shared:

[ ] Release [ ] Obtain [ ]Exchange (Release & Obtain)

I do hereby consent to the exchange and/or disclosure of information contained in my medical record between:

Dr. Rochelle Calvert

Phone Number: 619 261 8510

and

Name:_____

Street Address: _____

Phone & Fax Number:_____

Purpose of Request:

☐ Assessment and Evaluation
☐ Coordination of Care
☐ Continued Care, Treatment, and/or Aftercare
☐ Personal Use
☐ Other: _____
☐ Health Insurance Enrollment
☐ School/Educational Needs
☐ Legal Proceedings/Advice

The following information is to be disclosed: (please check)

☐ Discharge Summary
☐ Psychiatric Evaluation
☐ History & Physical Exam
☐ Psychological Evaluation
☐ Laboratory Reports
☐ Physician Orders
☐ Progress Notes
☐ Service Plans
☐ Quarterly Reports
☐ Treatment Plans
☐ School Records
☐ Mental Health Evaluation/ Assessments
☐ Mental Health Treatment

☐Other: _____

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____, or one calendar year from the date it was signed, whichever is sooner.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing, and that the revocation will not apply to information that has already been released based on this authorization.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep if confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations Section 164.524.

I have a right to receive a copy of this authorization. I would like a copy of this authorization. ☐ Yes ☐ No

_____	_____	_____
Signature of Patient	Relationship (if other than self)	Date
_____		_____
Signature of Minor (Ages 12-17)		Date

Statement of the Therapist

This document was discussed with the client and questions regarding its contents were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Signature of Therapist:_____ Date:_____

A COPY OF THIS CONSENT IS ACCEPTABLE IN LIEU OF THE ORIGINAL.