Dr. Jorge J. Asturias, PsyD, Inc.
A Professional Psychology Corporation

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Agency Name_____
Address_____ CA _____
Attention_____ Title_____

Patient Name_____
Date of Birth_____
Minor's Parent Name_____
Authorization Initiated by:_____
Relation to Patient: Self_____ Parent_____ Guardian_____ Attorney_____

_____The above-named patient is receiving clinical care from the office of Dr. Jorge J. Asturias, Licensed Clinical Psychologist, and is herby authorizing the release of treatment information to the above-named agency, clinic, and/or individual(s), either at your, his/her request, or voluntarily on his/her behalf, including:

_____Assessment _____Progress Notes _____Treatment Summary _____Entire Record
_____Other_____
Dates requested From:_____ To:_____

_____The above-named patient has requested professional services from Dr. Jorge J. Asturias, Licensed Clinical Psychologist, and is hereby authorizing the above-referenced agency, clinic, and/or individual(s) the release of personal / medical records and/or information for the purpose(s) of:

_____Diagnostic Clarification _____Psychiatric History _____Medication Management
_____Medical History _____School / Academic History _____Probation / Criminal History
_____Other:_____
Dates requested From:_____ To:_____

It is understood that the release or transfer of the specified information to any person or entity not specified herein is prohibited. Additional written authorization must be obtained for (a) a proposed new use of the information or (b) its transfer to another person or entity.

This authorization shall become effective on _____/_____/_____ and, if not earlier revoked, this authorization shall terminate on _____/_____/_____ This authorization is subject to revocation by the undersigned at any time, except to the extent that action has already been taken.

_____ _____
Client / Patient / Parent / Guardian / Conservator Signature **Date**