EAST BAY PSYCHOPHARMACOLOGY GROUP
3860 Blackhawk Road, Suite 120, Danville, CA 94506
Phone (925) 264-4069 FAX (925) 277-1116
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Authorization for Use and/or Disclosure of Patient Health Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document before signing.

Patient name:_____ D.O.B:_____

I hereby authorize:	To release information to:
East Bay Psychopharmacology Group	
(Health care provider to release in formation)	(Health care provider to release information)
3860 Blackhawk Road, Suite 120	
(address)	(address)
Danville, CA 94506	
(city, state, zip)	(city, state, zip)
(925) 264-4069	
(phone number)	(phone number)
(925) 277-1116	
(fax number)	(fax number)

I authorize the release of the following health information:

- O All health information about my medical history, mental health history, and treatment received; OR
- O Only the following types of health information (include dates):

_____

_____

_____

Expiration: This authorization expires one year from the date of my signature unless a different date is specified here:

_____

Revocation: I understand that I may cancel this authorization at any time, but I must do so by submitting my request for revocation to the EBPG authorized to release the information. My revocation will take effect upon receipt, except to the extent that other have acted in accordance on this agreement.

Notice of rights: I understand that I do not have to sign this authorization. By refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I understand that I have a right to receive a copy of this authorization.

I further understand that information disclosed by this authorization, may be re-disclosed (given to) another person or agency and may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving my health information by this authorization to disclose it, unless a new authorization for such a disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I have read both pages of this authorization and agree to the use and disclosure of health information specified above.

Patient or guardian signature Date

Print name of patient's guardian Relationship to patient