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(415) 926-7774 phone; (415) 591-7760
office@SanFranciscoPsych.com

Consent for Release and Exchange of Information

Patient Name (printed) ____ Date of Birth ______________

I hereby authorize San Francisco Psychiatry AND:

Name of Physician/Agency ____
Address ____
Phone Number ____
Fax Number ____
Email (if known) ____

to exchange information or records obtained in the course of my psychiatric treatment. This information may also include records and reports concerning Human Immunodeficiency Virus (HIV).

Disclosure will not be limited unless specified here by me to the following types of information: ____________________
____

I understand that these records are protected under state and/or federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. This consent shall be valid until termination of treatment with San Francisco Psychiatry unless otherwise specified: ____

My Rights: I do not have to sign this authorization. I may revoke this consent at any time in writing. This consent does not revoke the right to any disclosures already made. I am entitled to receive a copy of this consent upon my request.

Patient Signature ____ Date ____________________