

# ORANGE COAST PSYCHIATRIC ASSOCIATES

## Authorization for Disclosure of Confidential Mental Health Information

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby authorize \_\_\_\_\_ Phone: \_\_\_\_\_

to release/exchange information with: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Extent or Nature of Information to Released/Disclosed:

Verbal Consultation; Treatment Notes; Evaluation Records; and all Medical Records. This may include information related to HIV / AIDS, and Substance Abuse.

Purpose of Disclosure:

Coordination of Care

This authorization shall become effective immediately and shall remain in effect until (date) \_\_\_\_\_, except to the extent that action has been taken in reliance hereon and authorization is not earlier revoked. I understand that any requests to revise or cancel this authorization must be in writing. I hereby release OCPA, and his agents, from any and all liability arising from the release/disclosure of information as authorized hereby.

\_\_\_\_\_  
Patient/Parent/Guardian/Legal Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness

Date: \_\_\_\_\_

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