

Adina McGarr, Psy. D.
PSY 22253
Authorization For Medical Records
(Authorization To Disclose/Obtain Protected Health Information)

I hereby freely and voluntarily authorize Adina McGarr, Psy.D to disclose/obtain the following information to/from:

Name of Practitioner

Street Address

City/State/Zip Code

Telephone Number

Direct Information to:

Adina McGarr, Psy.D
28 W. Arrellaga
Santa Barbara, CA 93101
(818) 518-6775

The medical records to be disclosed may include information regarding diagnosis and treatment of **DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS**. Recipients of the medical records will be advised that federal regulations prohibit further disclosure of the medical records without your express written consent or as otherwise permitted by 42 CFR part 2.

Patient Name

Date of Birth

Address

Phone number

By **initialing** the spaces below, I specifically authorize the release or disclosure of the following information and/or records, if such information and/or medial records exist:

___ Discharge Summary

___ Treatment Plan

___ Physician Orders

___ Assessments/Reports

___ Billing Information

___ Other _____

This authorization is effective from date following signature and shall terminate one year from that date, I understand that I have a right to inspect or copy any information to be used or disclosed under this authorization.

I request a copy of this authorization: (initial) Yes ___ No ___

Signature of Patient/Legal Guardian

Relationship, if not patient

Date

Signature of Witness of above Signature

Date