



## **AUTHORIZATION TO USE/DISCLOSE HEALTH CARE INFORMATION**

Completion of this document authorizes the disclosure of individually identifiable health information, as set forth below, consistent with California and Federal Law concerning the privacy of such information.

Client Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Maiden or other name (if applicable): \_\_\_\_\_

I request and authorize (Summit Center staff) \_\_\_\_\_  
to release the health care information described below to:

Name: \_\_\_\_\_ phone number: \_\_\_\_\_

Please initial to specifically authorize the use and/or disclosure of:

**Emergency Room/Urgent Care Records**

**Admission Note**

**Hospital Records (nursing and progress notes)**

**Discharge Summary**

**Initial Psychological Evaluation**

**Clinical Summary**

**Medication History**

**Psychological Test Report**

**Billing Statements**

**Verbal Discussion of Case**

**Consultation Report (specify):**

The requested records or information is about health care provided during the following approximate time frame:

\_\_\_\_\_

Authorization expires: \_\_\_\_\_

I understand that I may rescind this consent at any time through written request stating that I do not give permission for further release or disclosure of information.

Date: \_\_\_\_\_ Client/Authorized Representative \_\_\_\_\_

(Signature)