Authorization of Release of Information

Anita Red, M.D.
960 East Green Street Suite 306, Pasadena, California 91106
Phone: (626) 793-0141, Fax: (626) 270-5961
Email: assistant@anitaredmd.com

Patient Name: _____ **Date of Birth:** _____

I hereby authorize the following agency/individual/provider to exchange information believed by them to be relevant to the services provided by Anita Red, M.D.

Provider/Individual:_____

Organization:_____

Address: _____

Email: _____

Phone: _____ **Fax:** _____

I understand that this information will be used for my treatment with Anita Red, M.D. I also understand that this release authorizes disclosure information regarding mental health, substance abuse, medical health, social history, and treatment. I also understand that I may revoke consent at any time but that it remains in effect until one year after the date of the signature or the date of discharge of treatment, whichever is later.

_____ _____ _____
Signature of Patient/Guardian Date Time

_____
Printed Name