BIO-BEHAVIORAL MEDICAL CLINICS, INC.

Authorization to Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual, which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: _____
Address: _____
_____

The information supplied is to be restricted to:

☐ Diagnosis ☐ Medical Record ☐ History & Physical ☐ Lab Work
☐ Progress Notes ☐ Assessment ☐ Other: _____

Name of individual authorized to receive and use the information. Requesting Psychiatrist or Clinician:

☐ Indira D. Adapa, MD
☐ Manolito V. Castillo, MD
☐ Leticia D. Chua, MD
☐ Mark B. Ting, MD
☐ James Backlund, LCSW
☐ Michelle Donaldson, MFT
☐ Michelle Rabin, LCSW
☐ David Sommers, LCSW, BCD, PhD
☐ H. Dan Smith, EdD, MFT

MAIL TO: 1060 W. Sierra, Suite 105; Fresno, CA 93711 or FAX: 559-437-1118

Photocopy and Expiration Instructions:	Expiration Date:
A photographic copy of this authorization shall be valid as the original. This authorization will expire on:	
If I do not specify an expiration date or event, this authorization will expire in six months of the following date:	

Signature: _____ Printed Name: _____

Address: _____ Phone: _____