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:

1.
Name: ______________________ Phone #: ______________

Address: ______________________ FAX #: ______________

2.
Name: ______________________ Phone #: ______________

Address: ______________________ FAX #: ______________

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, Name, Address & Phone #

______________________ ______________
Signature of Patient / Representative / Legal Guardian Printed Name

______________________ ______________
Address Phone #

Bio-Behavioral Medical Clinics