VERNON A. ROSARIO, MD, PHD
A MEDICAL CORPORATION
10850 WILSHIRE BLVD., SUITE 1210
LOS ANGELES, CA 90024
310-470-9775

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 et seq.

_____ _____/_____/_____
Patient Name Date of birth

I hereby authorize:_____
Name of Agency / Person / Organization

_____
Address of Agency / Person / Organization Telephone number

to release to Dr. Vernon A. Rosario written and oral information which pertains to the

☐ Medical ☐ Psychiatric / Psychological ☐ Drug & Alcohol ☐ School ☐ Other:_____

assessment and/or treatment of the patient for the treatment period of

_____/_____/_____ to _____/_____/_____

OR ☐ any and all records.

☐ I hereby authorize Dr. Vernon A. Rosario to release to the above indicated Agency, Person, or Organization written and oral information pertaining to Medical and Psychiatric assessment and/or treatment of the patient during the period under Dr. Rosario's treatment.
My signature below acknowledges my understanding and authorization and consent for the following:

1. This **RELEASE OF PATIENT INFORMATION AUTHORIZATION** is valid for 90 days if not revoked earlier.
2. This authorization covers both the release of that information specified above presently compiled and information to be compiled during the course of the patient's outpatient treatment.
3. Use of this authorization form may reveal or imply that mental health services have been/are being provided to the patient.
4. This authorization is subject to my revocation at any time except for information already released.
5. I understand that I have a right to receive a copy of this authorization.
6. A copy of this form is as valid as the original.
7. I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

_____
Patient / Representative / Spouse* / Financially Responsible Party*

_____ Date:____/____/____
Signature of Patient / Representative / Spouse* / Financially Responsible Party*

_____ Date:____/____/____
Witness to Above Signature

**A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.*

REVOCATION OF AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Written Revocation: I hereby revoke my authorization for the above specified information.

_____ Date:____/____/____
Signature of Patient/Parent/Guardian

Oral Revocation: Parent/Guardian revoked the authorization for the above specified patient.

_____
Means of Revocation