AUTHORIZATION TO RELEASE MEDICAL RECORDS

I HEREBY AUTHORIZE DISCLOSURE OF MEDICAL INFORMATION OBTAINED DURING THE COURSE OF MY EVALUATION AND/OR TREATMENT.

FROM:(NAME, ADDRESS, CITY, STATE, ZIP)

TO: (NAME, ADDRESS, CITY, STATE, ZIP)

DR. STEFANIE MIKULICS
1050 Las Tablas #2
Templeton, CA 93465
phone: 805-434-9441
fax: 805-434-9456

TO INCLUDE:

- ☐ ANY AND ALL MEDICAL RECORDS
- ☐ HISTORY & PHYSICAL(S)
- ☐ LABORATORY REPORTS
- ☐ PATHOLOGY REPORT(S)
- ☐ X-RAY REPORT(S)
- ☐ OPERATIVE REPORT(S)
- ☐ CONSULTATIONS
- ☐ RESULTS OF BLOOD TEST TO DETECT ANTIOBODIES/ANTIGEN TO THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) OR HTL V-III, THE PROBABLE CAUSITITIVE AGENT OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
- ☐ OTHER: _____

THIS INFORMATION IS NEEDED FOR THE PURPOSE OF:

I AM AWARE THAT THESE RECORDS MAY CONTAIN INFORMATION RELATED TO PSYCHIATRIC OR PSYCHOLOGICAL TESTING OR TREATMENT BIOFEEDBACK TRAINING AND/OR ALCOHOL/DRUG ABUSE.

THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION BY THE UNDERSIGNED AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN, AND IF NOT EARLIER REVOKED, THIS CONSENT SHALL BE COME INVALID ON YEAR FROM THE DATE.

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST.
COPY REQUESTED AND RECEIVED: ◯ YES ◯ NO

PATIENT'S NAME (PLEASE PRINT): _____

PATIENT'S DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____