ROBERT ZALEWSKI-ZARAGOZA, MD, INC.

1350 Columbia St. Ste. 800, San Diego, CA 92101
Phone: 619-255-1652 Fax: 619-324-7761

AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTHCARE INFORMATION

Patient Information

Patient Name _____ Street Address _____

Phone Number _____ City and Zip Code _____

Date of Birth _____ DoD Benefit Number or Last 4 of SSN _____

PLEASE INDICATE HOW YOU WOULD LIKE YOUR HEALTH CARE INFO SHARED:

☐ **Free Exchange of Information** (Release & Obtain BOTH) ☐ **Release only** ☐ **Obtain only**

I do hereby consent to the exchange and/or disclosure of information contained in my medical record between: (please select your provider(s))

- ☐ All providers at Robert Zalewski-Zaragoza, MD, Inc.
- ☐ Robert Zalewski-Zaragoza, MD
- ☐ Ruchira Densert, MD
- ☐ Robert McLay, MD
- ☐ Negean Shahnematollahi, PMHNP
- ☐ Milka Galvez, PMHNP
- ☐ Penny Greaves, PMHNP
- ☐ Robert LaVigne, PA-C
- ☐ Shannon Boyce, PA-C
- ☐ Kevin Huynh, PA-C
- ☐ Dennis Wood, Ph.D.

List person(s) or organizations that you are allowing release/obtain records. Please provide a phone number, fax number, and / or email address.
If you are obtaining records for yourself, please put your name and information for where you would like your records sent.

Name:_____**Phone/Fax/Email**_____

Name:_____**Phone/Fax/Email**_____

I specifically request that the following information:

- ☐ Mental health and medical history - diagnosis Records of outpatient treatment
- ☐ Records of hospitalization, inpatient treatment, all diagnostic and psychological assessments
- ☐ Other_____

Please note: emails may not be done through a secure platform. Although unlikely, there is a possibility that information can be intercepted and read by parties other than the intended recipient.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment (except information for a third party). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with policy. This disclosure of medical/psychiatric information complies with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et. Seq, California Civil Code.

I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt but will not be effective to the extent that this organization has taken action in reliance upon authorization.

I understand that the medical records and information to be released and/or obtained may contain information pertaining to psychiatric, drug and/or alcohol related evaluation and/or treatment, and may also contain confidential HIV (AIDS) related information, including educational, psychological and laboratory test results.

_____ _____

Printed Name of Authorizing Party (patient, parent, or guardian) Relationship to Patient (if other than self)

_____ _____

Signature of Authorizing Party (patient, parent, or guardian) Date