Circadian Mental Health Services
3702 4th Avenue
San Diego, CA 92103
Phone: 760-607-7257, Fax: 877-912-4883

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client's Name: _____
Date of Birth: _____

I hereby request and authorize Circadian Mental Health Services to release, disclose, and/or receive the medical information as indicated below for the patient listed above to/from the following health care provider, entity, or person:

Name: _____
Street Address: _____
City/State/Zip Code: _____
Phone: _____
Fax: _____

Duration: This authorization will become effective immediately and shall remain in effect until _____ or for one year from the date of signature.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party.

Check the box and initial which type of information is to be released and/or disclosed:

- □ **Mental Health** ____ Client/Representative's Initials
- □ **Alcohol/Drug** ____ Client/Representative's Initials
- □ **HIV Test Results** ____ Client/Representative's Initials
- □ **Other (Specify):** _____ ____ Client/Representative's Initials

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I request that the confidential information released and/or disclosed pursuant to this authorization be used for the following purposes only:
_____

I have a right to receive a copy of this authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative/Guardian Date

_____
Relationship of Patient to Representative