perlmanwellness++

Perlman Wellness Authorization for Release of Information (ROI)

Attn: Medical Records Department
3900 5th Avenue Suite 300, San Diego, CA 92103
medicalrecords@perlmanclinic.com
(P): 858.554.1212
(F): 858.795.1195

Date of Birth:	Patient's Legal Name: Last, First Middle	Patient's Phone Number:

I authorize the Perlman Clinic to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to:

Facility/Person:	Phone Number:	Fax Number:

Address:

Street City State Zip

Email Address:

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Perlman Clinic at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. I understand that I can request a copy of this form after I sign it.
6. By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient or Parent/Guardian/ Healthcare Power of Attorney/Executor	**Printed Name** of Patient or Patient Representative	**Date** – This Authorization will expire in 180 days from the above date.