

MICHAEL N. GARCIA, L.P.C.

AUTHORIZATION TO EXCHANGE INFORMATION

Patient's Name _____

Telephone _____ Date of Birth _____

SS# _____

Permanent Address _____

I understand that this authorization is voluntary. I understand that private health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that records may contain information regarding mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the exchange of the above-named patient's private information between the clinician and the parties named below. I understand that I may revoke this authorization at any time by notifying the clinician in writing. Parties authorized to exchange information:

1. Name _____ Telephone _____

Relationship to patient _____

Address _____ Initials _____

2. Name _____ Telephone _____

Relationship to patient _____

Address _____ Initials _____

Check appropriate type(s) of information to be exchanged: All Treatment plan(s)
 Diagnoses Psychiatric/ psychological evaluations Educational evaluations
 Physical evaluations Medication Claims/Eligibility/Benefits Progress reports
 Attendance Other

The purpose of this release is: Continuity of treatment Benefit management
 Administration of Worker's Compensation claim Employer Mandated Treatment Referral
 Subpoena or other legal process Other

I authorize the above exchange of pertinent private health information between Michael Garcia, L.P.C. and the above-named parties. This authorization is valid until _____.

Patient/ Parent/ Legal Guardian

Date

+1.434.981.7249
www.michaelgarcialpc.com

EFFECTIVE 01 October 2021