HELIOS PSYCHIATRY INC.
2995 Woodside Road, Suite 300
Woodside, CA 94062

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize:

Helios Psychiatry Inc
2995 Woodside Road
Suite 300
Woodside CA 94010

To release and share information on ________________________________(Patient's Name) __________________(Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:
Name____
Organization____
Address____
City ___________________________________
State _____________
Zip Code__________
Phone __________________________
Email ________________________

The medical information/records will be used for the following purpose:
____

This authorization is:

[ ] Unlimited (all records, including Substance Abuse, Mental Health, HIV

Diagnosis/Treatment)

[ ] Limited to the following medical information:

____
____
____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse Psychiatric/Mental Health Tests for Antibodies to HIV/ HIV Diagnosis/Treatment Genetic Information

DURATION:

This authorization shall be effective immediately and remain in effect until one year from the date of this release.

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

______________________________ Signature of patient *or legal/personal representative patient*

_______________________________ Patient's Name (PRINT)

_____________________ Patient's Date of Birth

Date ____________

If Applicable:

_____________________ signature of legal/personal representative for patient

____________________ printed name of legal / personal representative for patient

___________________ date