PHONE.: +1 (310) 207-1720
FAX: +1 (310) 207-1638
ADDRESS: 11633 San Vincente Blvd. Suite #106
E-MAIL: hello@oneneuro.com
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Request/Authorization to Release Confidential Records and Information

I hereby authorize: One Neuro

Person or facility: _____

_____

Address: _____

_____ Phone: _____

to release information from records about _____, born on _____ , for the following purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Rehabilitation program development or services
❑ Treatment planning ❑ Research ❑ Other: _____

In the boxes below, the information to be disclosed is marked by an X, the items not to be released have a line drawn through them and, page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

❑ Intake and discharge summaries _____ ❑ Medical history and evaluation(s) _____
❑ Mental health evaluations _____ ❑ Developmental and/or social history_____
❑ Educational records _____ ❑ Progress notes, and treatment or closing summary _____
❑ Other: _____ _____

Select only one:
❑ Please forward the records to the address in the letterhead at the top of this form.
❑ Please forward the records to the address written above.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ _____
Signature of client Printed name Date

_____ _____ _____ _____
Signature of parent/guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ _____ _____
Signature of witness Printed name Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records