AUTHORIZATION TO RELEASE AND DISCUSS HEALTHCARE INFORMATION

Name: _____ Date of Birth: _____

Previous Name: _____ Social Security: XXX-XX-_____

I authorize both parties below to discuss my mental/medical information and exchange documentation:

Name: _____

Address: _____

Suite: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Fax: _____

and

Alfredo Bimbela, PMHNP-BC, FNP-BC, PhD

3585 Maple Street, Suite 233
Ventura, CA 93003
Phone: 805-284-1783
Fax: 888-958-5269

This request and authorization applies to:

☐ Yes ☐ No Blood/Urine results.

☐ Yes ☐ No Psychiatric/mental health and substance use information relating to diagnosis, treatment, and medication.

☐ Yes ☐ No All medical/health care information, including medical status, diagnosis, evaluation, and treatment.

Other: _____

Print: _____

Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES UPON TERMINATION OF TREATMENT.