Anne Berner Calderwood, L.C.S.W.
PO Box 2244
Murphys, CA 95247
209-728-1250/FAX 209-728-2037

Authorization for Release/Exchange of Patient Information

Patient's Name: _____ DOB: _____
I, _____(patient/parent/guardian) hereby authorize:
Anne Berner Calderwood to ___release and/or ___exchange my health records and the information specified below during the course of treatment to/with the following person/agency:
Contact:_____
Address:_____
Phone/FAX/e-mail:_____

The disclosure of such records authorized herein is required for the following purpose(s):_____
_____
_____

The information released will be limited to the following information: _____

The requested information to be released *from* the above identified health provider/individual includes the following: _____
_____
_____
_____
_____

The patient has a right to refuse to sign this form and the provider will not make providing treatment a condition of signing this authorization. The patient understands that information that is used or disclosed according to this authorization may not be subject to re-disclosure by the recipient or used for any other purpose than its intended use. This authorization becomes effective on the date signed and can be revoked at any time upon written request. In the absence of a written request, this consent will expire on _____ (date). The information released is to be destroyed by the recipient when the release expires. A copy of this authorization is as valid as the original. I understand that I have a right to receive a copy of this consent for my records.

Signature of Patient/Legal Guardian:_____
Relationship: _____Date: _____